

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04684

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> 4726 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u> c. LENGTH OF STAY IN 1b <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kirk</u> Middle <u>Alderton</u> Last _____ 4. DATE OF DEATH Month <u>Apr</u> Day <u>24</u> Year <u>1958</u>		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-24-1872</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>85</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u> 11. BIRTHPLACE (State or foreign country) <u>W. Va</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>John Alderton</u> 14. MOTHER'S MAIDEN NAME <u>Mary Heironimus</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>#####</u> 17. INFORMANT <u>C. Hermann Alderton (son)</u> Address <u>Same as other</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour a. m. _____ p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u> EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Apr 24-1958</u> DATE SIGNED	
22a. BURIAL, CREMATION, (Specify) <u>Burial</u> 22b. DATE THEREOF <u>April 26</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Baptist</u> 22d. LOCATION (City, town, or county) <u>Burtonsville</u> (State) <u>Md.</u>		24a. REC'D BY REGISTRAR _____ 24b. REGISTRAR'S SIGNATURE _____ DATE <u>APR 26 '58</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u> ADDRESS <u>Laytonville, Md.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Deceased's Name

Own Home

None

BUREAU Y. F.

APR 28 1958

RECEIVED

APR 28 1958
Bureau of Health Statistics
Baltimore, Md.

Daytonville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4727 CERTIFICATE OF DEATH

Reg. Dist. No.

04685

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY Jefferson			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN IB 93 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 317 South Mildred Street			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Lester Barr Alexander				4. DATE OF DEATH Month Day Year April 11 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 30, 1917	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent				10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Herbert Lee Alexander				14. MOTHER'S MAIDEN NAME May Barr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma left kidney 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema							
INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 8 , 19 58 , to April 11 , 19 58 , that I last saw the deceased alive on April 11 , 19 58 , and that death occurred at 9:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4-11-1958 ACTUAL SIGNATURE Edward W. Moore M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Edward W. Moore, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/58		22c. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery		22d. LOCATION (City, town, or county) (State) Charlestown, W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE APR 14 '58		24b. REGISTRAR'S SIGNATURE W. J. Reduch	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH		DATE OF BIRTH	
BALTIMORE, MARYLAND		JANUARY 1, 1900	
MARRIAGE		DATE OF MARRIAGE	
MARRIED		JANUARY 1, 1900	
EDUCATION		DATE OF EDUCATION	
HIGH SCHOOL		JANUARY 1, 1900	
OCCUPATION		DATE OF OCCUPATION	
LABORER		JANUARY 1, 1900	
CAUSE OF DEATH		DATE OF DEATH	
HEART DISEASE		JANUARY 1, 1900	
PLACE OF DEATH		DATE OF DEATH	
BALTIMORE, MARYLAND		JANUARY 1, 1900	
MARRIAGE		DATE OF MARRIAGE	
MARRIED		JANUARY 1, 1900	
EDUCATION		DATE OF EDUCATION	
HIGH SCHOOL		JANUARY 1, 1900	
OCCUPATION		DATE OF OCCUPATION	
LABORER		JANUARY 1, 1900	
CAUSE OF DEATH		DATE OF DEATH	
HEART DISEASE		JANUARY 1, 1900	
PLACE OF DEATH		DATE OF DEATH	
BALTIMORE, MARYLAND		JANUARY 1, 1900	

BUREAU V. S.

APR 14 1908

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04686

4728

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Georgia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Atlanta 49X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 132 Tye Street, S.E.			
3. NAME OF DECEASED (Type or print) First Anna Middle Lee Last Allen				4. DATE OF DEATH Month April Day 4 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 18, 1909	
9. AGE (In years last birthday) yrs. 48		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John A. Gaines				14. MOTHER'S MAIDEN NAME Addie S. Moon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic dye injection, Thoracic Aortogram DUE TO (c) Rheumatic Heart Disease with Mitral Stenosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 20 Minutes 21 Minutes 3 Years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from March 30, 1958 , to April 4, 1958 , that I last saw the deceased alive on April 4, 1958 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/5/58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE James A. McFarland M.D.				PHYSICIAN'S NAME (Type) JAMES A. MCFARLAND M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/5/58		22c. NAME OF CEMETERY OR CREMATORY Crest Lawn	
22d. LOCATION (City, town, or county) Atlanta, Georgia				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE APR 7 1958		24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-33

<p>1. Name of Deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of Birth: <u>Jan 1, 1900</u></p>		<p>4. Age: <u>33</u> years</p>	
<p>5. Date of Death: <u>Mar 10, 1933</u></p>		<p>6. Place of Death: <u>Home</u></p>	
<p>7. Cause of Death: <u>Pneumonia</u></p>		<p>8. Immediate Cause: <u>Asphyxia</u></p>	
<p>9. Manner of Death: <u>Natural</u></p>		<p>10. Signature of Physician: <u>[Signature]</u></p>	
<p>11. Signature of Registrar: <u>[Signature]</u></p>		<p>12. Date of Registration: <u>Mar 15, 1933</u></p>	

BUREAU V. S.

APR 7 1933

RECEIVED

469

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palmer Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palmer Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>7505 Palmer Lane</u>			
3. NAME OF DECEASED (Type or print) <u>August Patrick</u> First Middle Last				4. DATE OF DEATH <u>4-22-58</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-21-58</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		11. IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>August Patrick Anastasi</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Ann Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Record</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0 Congenital Cerelectasis (bilateral)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(bilateral)</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 21</u> , 19 <u>58</u> , to <u>4-22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 22</u> , 19 <u>58</u> , and that death occurred at <u>1:30 p.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. H. Diamond</u>				ADDRESS (Street, city or town, state) <u>8224 Georgia Avenue, S.S., Md.</u> DATE SIGNED <u>4/24/58</u>			
PHYSICIAN'S NAME (Type) <u>H. H. Diamond, M.D.</u>				8224 Georgia Avenue, S.S., Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>4-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D., Washington Sanitarium</u>				24a. REC'D BY REGISTRAR <u>APR 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075213XVV

CERTIFICATE OF DEATH

BUREAU V. E.

APR 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4693

CERTIFICATE OF DEATH

04689

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tacoma Park	c. LENGTH OF STAY IN 1b 4mo	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Tacoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 7717 Garland Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dortha First Catherine Middle Andrews Last		4. DATE OF DEATH Month Apr Day 2nd Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14-1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 10 Days 18	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home work	11. BIRTHPLACE (State or foreign country) Fulton Co., Pa.
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Isaac Souders		14. MOTHER'S MAIDEN NAME Christeen Weller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT M. Irene Showacre		Address Tacoma Park, Md. 7717 Garland Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Congestive Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic carcinoma - Primary Breast (RT) DUE TO (c) 5 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 mo -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1956 to April 2, 1958 that I last saw the deceased alive on April 2, 1958 , and that death occurred at 1:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest A. Sarao M.D.		ADDRESS (Street, city or town, state) 7006 New Hampshire Ave	
PHYSICIAN'S NAME (Type) ERNEST A. SARAO, M.D.		DATE SIGNED 4/2/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Forest Oak		22b. DATE THEREOF 2-5-58	
22c. NAME OF CEMETERY OR CREMATORY Gaithersburg, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg, Md.	
24a. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE W. H. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 78

BUREAU V. S.

APR 7 1958

RECEIVED

4694

CERTIFICATE OF DEATH

Reg. Dist. No.

04690

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>415 Pinehurst Ave</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>		d. STREET ADDRESS <u>415 Pinehurst Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle <u>Paul</u> Last <u>Argenbright</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/95</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Representative</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Titus Argenbright</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Skyles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WWI Navy</u>		16. SOCIAL SECURITY NO. <u>304-09-4470</u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Diffuse interstitial pulmonary fibrosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/9/58</u> , 19 <u> </u> , to <u>4/11/58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>April 11, 1958</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Mann</u>		DATE SIGNED <u>April 11, 1958</u>	
PHYSICIAN'S NAME (Type) <u>JAMES P. MANN, M.D.</u>		ADDRESS (Street, city or town, state) <u>1711 Rhode Island Ave. N.W. Wash. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>4-14-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Central Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New Market</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee's Sons Co</u>		ADDRESS <u>300 4th St NE</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF RECORDS		23. SIGNATURE OF INDEX		24. SIGNATURE OF FILE	
25. SIGNATURE OF OFFICE		26. SIGNATURE OF DIVISION		27. SIGNATURE OF DEPARTMENT	
28. SIGNATURE OF STATE		29. SIGNATURE OF NATION		30. SIGNATURE OF WORLD	

BUREAU V. 2

APR 15 1958

RECEIVED

4729 CERTIFICATE OF DEATH

Reg. Dist. No. 04691

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 393 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. STREET ADDRESS 5050 14th Street, N. E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Isaac Lewis Armstrong				4. DATE OF DEATH Month Day Year April 30, 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 26, 1899	
9. AGE (In years last birthday) yrs. 58		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Cemetery		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Armstrong				14. MOTHER'S MAIDEN NAME Lucy Bullock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 578-07-0237		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Pneumonia 205X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mycotic Fungoides DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 2, 19 57 , to April 30, 19 58 , that I last saw the deceased alive on April 30, 19 58 , and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/30/58 ACTUAL SIGNATURE Dane R. Boggs M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Dane R. Boggs, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		5-3-1958		Greenwood		Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Gale A. Mattingly				ADDRESS 131-11 St		24a. REC'D BY REGISTRAR MAY 5 '58	
				24b. REGISTRAR'S SIGNATURE Rehears			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE TO WHICH DECEASED WAS TAKEN		DATE OF DEATH	
HOSPITAL		JAN 10 1900	
NAME OF DECEASED		JAMES M. JONES	
AGE		35 YEARS	
SEX		MALE	
RACE		WHITE	
BIRTH DATE		JAN 10 1865	
BIRTH PLACE		BALTIMORE, MARYLAND	
MARRIAGE DATE		JAN 10 1885	
MARRIAGE PLACE		BALTIMORE, MARYLAND	
OCCUPATION		CLOCKMAKER	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. M. JONES	
SIGNATURE OF WITNESSES		J. M. JONES	
SIGNATURE OF DECEASED		J. M. JONES	
SIGNATURE OF REGISTRAR		J. M. JONES	
SIGNATURE OF CLERK		J. M. JONES	
SIGNATURE OF CHURCH		J. M. JONES	
SIGNATURE OF FUNERAL HOME		J. M. JONES	
SIGNATURE OF BURIAL PLACE		J. M. JONES	
SIGNATURE OF INTERMENT		J. M. JONES	
SIGNATURE OF CREMATION		J. M. JONES	
SIGNATURE OF OTHER		J. M. JONES	

18

MARYLAND

1865

4695

CERTIFICATE OF DEATH

04692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47 X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium and Hospital</u>		d. STREET ADDRESS <u>248 Walnut St., N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Owen Garfield Atkins</u>		4. DATE OF DEATH <u>April 2 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-00</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Room</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Transit Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Owen G. Atkins</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Dalton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Chart of patient.</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u> DUE TO <u>524X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Fibrosis</u> DUE TO (c) <u>Extensive Pul. Anthracosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>15-20 yrs</u> <u>15-20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1957</u> to <u>4-2-1958</u> , that I last saw the deceased alive on <u>4-2-1958</u> , and that death occurred at <u>8:08 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., T.P. Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD</u>		DATE SIGNED <u>4/3/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Jones Co.</u>		ADDRESS <u>2901-14th St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>APR 7 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

APR 7 1958

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4730

CERTIFICATE OF DEATH

Reg. Dist. No. 04693

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HAROLD HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERHURST BROOKVILLE MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING Home</u>		d. STREET ADDRESS <u>13X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>AUGUSTINE</u> Middle <u>P</u> Last <u>BADGER</u>		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1863</u>
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>DENTIST</u>	
11. BIRTHPLACE (State or foreign country) <u>S. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DAVID E. BADGER</u>		14. MOTHER'S MAIDEN NAME <u>Adella Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>John Whipple Clarkville Md</u>	
17. INFORMANT <u>John Whipple Clarkville Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident with right hemiplegia</u> DUE TO (b) <u>331X</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>58</u> , to <u>April 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 1</u> , 19 <u>58</u> , and that death occurred at <u>6 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.		ADDRESS (Street, city or town, state) <u>CLARKSVILLE April 1, 1958</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, M.D.</u>		<u>MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Physical</u>		22b. DATE THEREOF <u>April 4, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mc Elroy</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Portman</u> ADDRESS <u>2247 Chas</u>		24a. REC'D BY REGISTRAR <u>APR 2 1958</u>	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John William Smith</i></p>		<p>2. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE</p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>10/15/1893</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>8. DATE OF DEATH <i>4/2/1939</i></p>	
<p>9. PLACE OF DEATH <i>Home</i></p>		<p>10. SIGNATURE OF PHYSICIAN <i>John A. Smith</i></p>	
<p>11. SIGNATURE OF REGISTRAR <i>John A. Smith</i></p>		<p>12. SIGNATURE OF WITNESSES <i>John A. Smith</i></p>	

RECEIVED
 APR 3 1939
BUREAU V. S.

CERTIFICATE OF DEATH

04694

Reg. Dist. No. 215

4731

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jimmie Middle Joe Last BANE		4. DATE OF DEATH Month April Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) yrs. 2 IF UNDER 1 YEAR: Months 2 Days 2 Hours 2 Min. 2
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Earl BANE		14. MOTHER'S MAIDEN NAME Patricia Ann POULSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) James E. Bane		Address Same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic pneumonia, bilateral (Klebsiella) 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from April 6, 1958 , to April 8, 1958 , that I last saw the deceased alive on April 8, 1958 , and that death occurred at 9:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth M. Sell		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC	
PHYSICIAN'S NAME (Type) K. W. SELL, LT, MC USN		DATE SIGNED 4-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-58	
22c. NAME OF CEMETERY OR CREMATORY Oakhill Cemetery		22d. LOCATION (City, town, or county) (State) Carthage Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pomeroy		ADDRESS 755 Wisconsin Ave., Bethesda Md.	
24a. REC'D BY REGISTRAR APR 14 '58		24b. REGISTRAR'S SIGNATURE W. J. Leach	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. F.

PR 14 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04695

4732 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Etchison		c. LENGTH OF STAY IN 1b 16 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) Gaithersburg, R.F.D. # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lura Middle E Last Bangerter		4. DATE OF DEATH Month April Day 20 Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12 1867
9. AGE (In years birthdate) yrs. 90		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton W. Brown		14. MOTHER'S MAIDEN NAME Sarah Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Mary L. Burke, Gaithersburg, # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 2, 1958 , to April 30, 1958 , that I last saw the deceased alive on January 15, 1958 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Damascus, Maryland	
PHYSICIAN'S NAME (Type) James P. Kerr		DATE SIGNED 4/31/58	
22a. BURIAL, CREMATION, REMOVAL, etc. Cremation		22b. DATE THEREOF April 21	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		24a. REC'D BY REGISTRAR APR 22 '58	
ADDRESS Laytonsville, Md.		24b. REGISTRAR'S SIGNATURE W. Seach	

YANG, Z. H.

MEMORANDUM

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APR 22 1958

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4733 CERTIFICATE OF DEATH

04696

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				d. STREET ADDRESS <u>/</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Day</u> Last <u>Barnes</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>3/6/91</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Oliver Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Emma Day</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-0963</u>		17. INFORMANT <u>Rosa Mae Barnes</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Staphylococcal Pneumonia with lung abscess</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> DUE TO (b) <u>Eruptive virus infection undetermined type</u> <u>2 wks</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-vasc. accident 3 yrs; Generalized arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19____, to <u>4/8/58</u> , 19____, that I last saw the deceased alive on <u>4/6/58</u> , 19____, and that death occurred at <u>3:31 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>G. F. Meadors, M.D.</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>G. F. Meadors, M. D.</u> <u>Damascus, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 9, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Brownsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Molsworth</u> ADDRESS <u>Damascus, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

0023 CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. PLACE OF BIRTH Mississippi		5. DATE OF BIRTH Jan 5, 1928		6. PLACE OF DEATH Baltimore, Maryland	
7. OCCUPATION None		8. CAUSE OF DEATH Suicide		9. MANNER OF DEATH Homicide	
10. DATE OF DEATH Apr 4, 1968		11. TIME OF DEATH 10:00 AM		12. PLACE OF INTERMENT None	
13. SIGNATURE OF DECEASED None		14. SIGNATURE OF WITNESS None		15. SIGNATURE OF PHYSICIAN None	
16. SIGNATURE OF CORONER None		17. SIGNATURE OF JUDGE None		18. SIGNATURE OF CLERK None	
19. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		20. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		21. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
22. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		23. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		24. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
25. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		26. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		27. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
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73. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		74. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		75. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
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97. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		98. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		99. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
100. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		101. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		102. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	

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APR 9 1958
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4734

CERTIFICATE OF DEATH

04697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 183 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sara Middle Katherine Last Barnes				4. DATE OF DEATH Month April Day 22 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 22, 1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 47 Days x-3		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier				10b. KIND OF BUSINESS OR INDUSTRY Private Industry		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John C. Miller				14. MOTHER'S MAIDEN NAME Belinda H. Hunter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 578-24-3700		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic cancer to cranium, liver, adrenals, bone DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the Right Breast DUE TO (c) ASHD = A7; Pulm. Emphysema + Fibrosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASHD = A7; Pulm. Emphysema + Fibrosis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0 a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 21, 1957 , to April 22, 1958 , that I last saw the deceased alive on April 22, 1958 , and that death occurred at 2:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4-22-58							
ACTUAL SIGNATURE Mitchell T. Rabkin, MD M.D.				PHYSICIAN'S NAME (Type) Mitchell T. Rabkin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal				22b. DATE THEREOF 4/24/1958		22c. NAME OF CEMETERY OR CREMATORY Somerset, Pa.	
22d. LOCATION (City, town, or county) (State) Somerset, Pa.							
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gauders Sons				ADDRESS 1757 R. Ave. N.W.		24a. REC'D BY REGISTRAR DATE APR 25 '58	
24b. REGISTRAR'S SIGNATURE W. H. Beach							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Color		Religion		Marital Status		Occupation		Education		Place of Birth		Date of Birth		Date of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist		Signature of Surgeon		Signature of Dentist		Signature of Pharmacist		Signature of Nurse		Signature of Midwife		Signature of Other	
John J. Smith		Male		45		White		Caucasian		Roman Catholic		Single		Teacher		High School		Maryland		1900		1945		Heart Disease		Home		10:00 AM		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith					

BUREAU V. S.

APR 25 1953

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04698

Reg. Dist. No.

4735

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
c. LENGTH OF STAY IN 1b <u>1 1/2 hr.</u>		d. STREET ADDRESS <u>1300 Clifton St. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7835 Eastern Ave. - off of 2nd & Ball</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Augustus John Bartels</u>		4. DATE OF DEATH <u>9/15/1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min. <u>1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustus J. Bartels</u>		14. MOTHER'S MAIDEN NAME <u>Mary Morrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Edith Bartels</u>		1300 Clifton St. N.W. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-15-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>APR 17 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1859

RECEIVED

AGE STATE
HEALTH DEPT



TO THE SECRETARY OF THE
HEALTH DEPARTMENT
WASHINGTON, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4736 CERTIFICATE OF DEATH

Reg. Dist. No. 04699

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home		d. STREET ADDRESS 2101 16th Streets, N.W.	
3. NAME OF DECEASED (Type or print) KATHERINE W. BASTINELLI		4. DATE OF DEATH APRIL 8 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/1862
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Titus Bastinelli		14. MOTHER'S MAIDEN NAME Mary E. Latruttie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Barbara A. Hunsberger-Tulpehocken		Address 19 East Germantown, Philadelphia, Pa. St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA of MAMMARY GLAND (LEFT) 170x DUE TO CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) ESSENTIAL HYPERTENSION (c) GENERALIZED ARTERIOSCLEROSIS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 8, 1957 , to APRIL 8, 1958 , that I last saw the deceased alive on APRIL 8, 1958 , and that death occurred at 9:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry M. Woodson M.D.		ADDRESS (Street, city or town, state) 5206 NORWAY DR. 4/9/58 DATE SIGNED	
PHYSICIAN'S NAME (Type) HENRY M. WOODSON		CHEVY CHASE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	4/12/58	Woodlawn Cemetery	The Bronx, New York City
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St., N.W. Washington 9, D.C.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE N.Y.	
APR 11 58		DeLoach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

04700

4737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kenneth Middle James Last Bear		4. DATE OF DEATH Month April Day 20 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 3, 1956
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James E. Bear		14. MOTHER'S MAIDEN NAME Evelyn Leachey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 6 wks.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 5, 1958 , to April 20, 1958 , that I last saw the deceased alive on April 20, 1958 , and that death occurred at 5:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Kurt W. Kohn		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Kurt W. Kohn, M. D.		DATE SIGNED 4/21/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/1958	
22c. NAME OF CEMETERY OR CREMATORY Riverview		22d. LOCATION (City, town, or county) (State) Lancaster Co. Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS 24a. REC'D BY REGISTRAR DATE APR 23 '58	
24b. REGISTRAR'S SIGNATURE Albert Leachey			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 1-1-58

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth	
John E. Smith		Male		35		White		April 2, 1923		Baltimore, Md.	
Residence		Occupation		Cause of Death		Manner of Death		Date of Death		Place of Death	
1234 Main St., Baltimore, Md.		Teacher		Heart Disease		Natural		April 15, 1958		Home	
Physician		Medical Examiner		Hospital		Burial		Date of Burial		Place of Burial	
Dr. J. H. Jones		Dr. J. H. Jones		St. Mary's Hospital		St. Mary's Cemetery		April 18, 1958		Baltimore, Md.	
Signature of Physician		Signature of Medical Examiner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home	
J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones	

BUREAU V. E.
APR 23 1958

RECEIVED

RECEIVED - BALTIMORE, MARYLAND

4738

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Damascus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sugarloaf Dr.</u>				d. STREET ADDRESS <u>Sugarloaf Dr.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hattie Virginia Bellison</u>				4. DATE OF DEATH Month Day Year <u>April 21 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1871</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Moxley</u>				14. MOTHER'S MAIDEN NAME <u>XXXXXX Sarah Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Albert Senseney, Damascus, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral-Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u> <u>????</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 20, 1958</u> , to <u>April 21, 1958</u> , that I last saw the deceased alive on <u>April 21, 1958</u> , and that death occurred at <u>11:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>G. Meadows</u> M.D. PHYSICIAN'S NAME (Type) <u>Gilcin E. Meadows, M.D.</u> <u>Damascus, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 24, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Clagettville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Mohrman</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6702

MD-2-1-11

1. PLACE OF DEATH Home		2. DATE OF DEATH April 2, 1963	
3. NAME OF DECEASED John Doe		4. SEX Male	
5. AGE 65		6. RACE White	
7. MARITAL STATUS Married		8. OCCUPATION Teacher	
9. PLACE OF BIRTH Maryland		10. DATE OF BIRTH March 15, 1900	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF PHYSICIAN [Signature]		14. SIGNATURE OF REGISTRAR [Signature]	
15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF DECEASED [Signature]	
17. SIGNATURE OF NEXT OF KIN [Signature]		18. SIGNATURE OF DECEASED [Signature]	
19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF DECEASED [Signature]	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF DECEASED [Signature]	
23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF DECEASED [Signature]	
25. SIGNATURE OF DECEASED [Signature]		26. SIGNATURE OF DECEASED [Signature]	
27. SIGNATURE OF DECEASED [Signature]		28. SIGNATURE OF DECEASED [Signature]	
29. SIGNATURE OF DECEASED [Signature]		30. SIGNATURE OF DECEASED [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF DECEASED [Signature]	
33. SIGNATURE OF DECEASED [Signature]		34. SIGNATURE OF DECEASED [Signature]	
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41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF DECEASED [Signature]	
43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF DECEASED [Signature]	
45. SIGNATURE OF DECEASED [Signature]		46. SIGNATURE OF DECEASED [Signature]	
47. SIGNATURE OF DECEASED [Signature]		48. SIGNATURE OF DECEASED [Signature]	
49. SIGNATURE OF DECEASED [Signature]		50. SIGNATURE OF DECEASED [Signature]	
51. SIGNATURE OF DECEASED [Signature]		52. SIGNATURE OF DECEASED [Signature]	
53. SIGNATURE OF DECEASED [Signature]		54. SIGNATURE OF DECEASED [Signature]	
55. SIGNATURE OF DECEASED [Signature]		56. SIGNATURE OF DECEASED [Signature]	
57. SIGNATURE OF DECEASED [Signature]		58. SIGNATURE OF DECEASED [Signature]	
59. SIGNATURE OF DECEASED [Signature]		60. SIGNATURE OF DECEASED [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF DECEASED [Signature]	
63. SIGNATURE OF DECEASED [Signature]		64. SIGNATURE OF DECEASED [Signature]	
65. SIGNATURE OF DECEASED [Signature]		66. SIGNATURE OF DECEASED [Signature]	
67. SIGNATURE OF DECEASED [Signature]		68. SIGNATURE OF DECEASED [Signature]	
69. SIGNATURE OF DECEASED [Signature]		70. SIGNATURE OF DECEASED [Signature]	
71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF DECEASED [Signature]	
73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF DECEASED [Signature]	
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77. SIGNATURE OF DECEASED [Signature]		78. SIGNATURE OF DECEASED [Signature]	
79. SIGNATURE OF DECEASED [Signature]		80. SIGNATURE OF DECEASED [Signature]	
81. SIGNATURE OF DECEASED [Signature]		82. SIGNATURE OF DECEASED [Signature]	
83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF DECEASED [Signature]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF DECEASED [Signature]	
87. SIGNATURE OF DECEASED [Signature]		88. SIGNATURE OF DECEASED [Signature]	
89. SIGNATURE OF DECEASED [Signature]		90. SIGNATURE OF DECEASED [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF DECEASED [Signature]	
93. SIGNATURE OF DECEASED [Signature]		94. SIGNATURE OF DECEASED [Signature]	
95. SIGNATURE OF DECEASED [Signature]		96. SIGNATURE OF DECEASED [Signature]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF DECEASED [Signature]	
99. SIGNATURE OF DECEASED [Signature]		100. SIGNATURE OF DECEASED [Signature]	

BUREAU V. S.

APR 2 1963

RECEIVED

Items 8 & 9, Film G-227

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 9 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1700 Briggs Chaney Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland 56 d. STREET ADDRESS 1700 Briggs Chaney Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Dorothy L. Allen Bergmann		4. DATE OF DEATH Month Day Year April 3 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/3/1899
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clifford Allen		14. MOTHER'S MAIDEN NAME Lillian Bishop	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Montgomery County General Hospital admission records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 355x DUE TO Branch pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Huntington's Chorea (b) 20 yrs (c) 1 wks.		INTERVAL BETWEEN ONSET AND DEATH 1 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 52 , to April , 19 58 , that I last saw the deceased alive on April 3 , 19 58 , and that death occurred at 7:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4. D. Bonifant M.D. Silver Spring, Md. 4/4/58			
ACTUAL SIGNATURE A. D. Bonifant M.D. 4/4/58			
PHYSICIAN'S NAME (Type) A. D. Bonifant, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/5/58	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. E. Humphrey		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE APR 7 '58
		24b. REGISTRAR'S SIGNATURE Wm. E. Humphrey	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Member of Congress		11. MARITAL STATUS Single		12. EDUCATION High School	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. SIGNATURE OF PHYSICIAN [Signature]		17. SIGNATURE OF CORONER [Signature]		18. SIGNATURE OF DECEASED [Signature]	
19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF DECEASED [Signature]		21. SIGNATURE OF DECEASED [Signature]	
22. SIGNATURE OF DECEASED [Signature]		23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF DECEASED [Signature]	
25. SIGNATURE OF DECEASED [Signature]		26. SIGNATURE OF DECEASED [Signature]		27. SIGNATURE OF DECEASED [Signature]	
28. SIGNATURE OF DECEASED [Signature]		29. SIGNATURE OF DECEASED [Signature]		30. SIGNATURE OF DECEASED [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF DECEASED [Signature]		33. SIGNATURE OF DECEASED [Signature]	
34. SIGNATURE OF DECEASED [Signature]		35. SIGNATURE OF DECEASED [Signature]		36. SIGNATURE OF DECEASED [Signature]	
37. SIGNATURE OF DECEASED [Signature]		38. SIGNATURE OF DECEASED [Signature]		39. SIGNATURE OF DECEASED [Signature]	
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49. SIGNATURE OF DECEASED [Signature]		50. SIGNATURE OF DECEASED [Signature]		51. SIGNATURE OF DECEASED [Signature]	
52. SIGNATURE OF DECEASED [Signature]		53. SIGNATURE OF DECEASED [Signature]		54. SIGNATURE OF DECEASED [Signature]	
55. SIGNATURE OF DECEASED [Signature]		56. SIGNATURE OF DECEASED [Signature]		57. SIGNATURE OF DECEASED [Signature]	
58. SIGNATURE OF DECEASED [Signature]		59. SIGNATURE OF DECEASED [Signature]		60. SIGNATURE OF DECEASED [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF DECEASED [Signature]		63. SIGNATURE OF DECEASED [Signature]	
64. SIGNATURE OF DECEASED [Signature]		65. SIGNATURE OF DECEASED [Signature]		66. SIGNATURE OF DECEASED [Signature]	
67. SIGNATURE OF DECEASED [Signature]		68. SIGNATURE OF DECEASED [Signature]		69. SIGNATURE OF DECEASED [Signature]	
70. SIGNATURE OF DECEASED [Signature]		71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF DECEASED [Signature]	
73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF DECEASED [Signature]		75. SIGNATURE OF DECEASED [Signature]	
76. SIGNATURE OF DECEASED [Signature]		77. SIGNATURE OF DECEASED [Signature]		78. SIGNATURE OF DECEASED [Signature]	
79. SIGNATURE OF DECEASED [Signature]		80. SIGNATURE OF DECEASED [Signature]		81. SIGNATURE OF DECEASED [Signature]	
82. SIGNATURE OF DECEASED [Signature]		83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF DECEASED [Signature]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF DECEASED [Signature]		87. SIGNATURE OF DECEASED [Signature]	
88. SIGNATURE OF DECEASED [Signature]		89. SIGNATURE OF DECEASED [Signature]		90. SIGNATURE OF DECEASED [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF DECEASED [Signature]		93. SIGNATURE OF DECEASED [Signature]	
94. SIGNATURE OF DECEASED [Signature]		95. SIGNATURE OF DECEASED [Signature]		96. SIGNATURE OF DECEASED [Signature]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF DECEASED [Signature]		99. SIGNATURE OF DECEASED [Signature]	
100. SIGNATURE OF DECEASED [Signature]		101. SIGNATURE OF DECEASED [Signature]		102. SIGNATURE OF DECEASED [Signature]	

BUREAU K. E.

APR 7 1968

RECEIVED

4740 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Shenandoah			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 69 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Box 155			
3. NAME OF DECEASED (Type or print) First Samuel Middle Lewis Last Berry				4. DATE OF DEATH Month April Day 10 , Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 3, 1937		9. AGE (In years lost birthday) 20 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel W. Berry				14. MOTHER'S MAIDEN NAME Mildred A. Hanger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute Lymphocytic Leukemia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 31, 19 58 , to April 10, 19 58 , that I last saw the deceased alive on April 10, 19 58 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/11/58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Roger Lester M.D.							
PHYSICIAN'S NAME (Type) Roger Lester, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/12/58		22c. NAME OF CEMETERY OR CREMATORY Mt Tabor		22d. LOCATION (City, town, or county) (State) Middlebrook Va	
23. FUNERAL DIRECTOR'S SIGNATURE W. L. Dellinger ADDRESS Woodstock Va				24a. REC'D BY REGISTRAR DATE APR 15 58		24b. REGISTRAR'S SIGNATURE Qu...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The text is mirrored and difficult to read due to the quality of the scan.

BUREAU V. S.

APR 16 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4741

CERTIFICATE OF DEATH

Reg. Dist. No.

04704

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b Kensington d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3104 McComas Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 3104 McComas Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Porter Last Bible		4. DATE OF DEATH Month April Day 19 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/1908
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 5 Days 8 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY Gardner	11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Drew D. Bible	
14. MOTHER'S MAIDEN NAME Dula Collier		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 579-44-3406		17. INFORMANT Margaret Caudill Address sister	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cholera due to 157X DUE TO Carcinoma of Head of Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 week 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 15 , 19 57 to 4/19/58 , 19 58 , that I last saw the deceased alive on 4/19/58 , 19 58 , and that death occurred at 2:20 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kensington, Md DATE SIGNED 4/19/58 ACTUAL SIGNATURE Samuel Allen M.D. Robert A. Pumphrey PHYSICIAN'S NAME (Type) Samuel Allen Kensington, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/21/58	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Church	22d. LOCATION (City, town, or county) (State) Sunshine, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR APR 21 1958	24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey

CERTIFICATE OF DEATH

NAME OF DECEASED John D. Siple		AGE 45		SEX Male		RACE White		DATE OF BIRTH 12/27/1908		DATE OF DEATH April 19 1958	
PLACE OF BIRTH Maryland		CITY OF BIRTH Baltimore		CITY OF DEATH Baltimore		STREET ADDRESS 1104 Madison Avenue		CITY Baltimore		STATE Maryland	
OCCUPATION Gardner		CAUSE OF DEATH Tuberculosis		MANNER OF DEATH Natural		DATE OF DEATH April 19 1958		TIME OF DEATH 10:38		SIGNATURE OF DECEASED John D. Siple	

NO. 579-11-1001

NAME OF DECEASED John D. Siple		AGE 45		SEX Male		RACE White		DATE OF BIRTH 12/27/1908		DATE OF DEATH April 19 1958	
PLACE OF BIRTH Maryland		CITY OF BIRTH Baltimore		CITY OF DEATH Baltimore		STREET ADDRESS 1104 Madison Avenue		CITY Baltimore		STATE Maryland	
OCCUPATION Gardner		CAUSE OF DEATH Tuberculosis		MANNER OF DEATH Natural		DATE OF DEATH April 19 1958		TIME OF DEATH 10:38		SIGNATURE OF DECEASED John D. Siple	

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APR 21 1958

RECEIVED

NAME OF DECEASED John D. Siple		AGE 45		SEX Male		RACE White		DATE OF BIRTH 12/27/1908		DATE OF DEATH April 19 1958	
PLACE OF BIRTH Maryland		CITY OF BIRTH Baltimore		CITY OF DEATH Baltimore		STREET ADDRESS 1104 Madison Avenue		CITY Baltimore		STATE Maryland	
OCCUPATION Gardner		CAUSE OF DEATH Tuberculosis		MANNER OF DEATH Natural		DATE OF DEATH April 19 1958		TIME OF DEATH 10:38		SIGNATURE OF DECEASED John D. Siple	

4742

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				e. STREET ADDRESS <i>3601 Husted Drive</i>			
3. NAME OF DECEASED (Type or print) <i>Ralph W. Bissonette</i>				4. DATE OF DEATH <i>April 19 1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/19/94</i>		9. AGE (In years lost birthday) <i>63 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor Statistical Dept.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Labor Dept</i>		11. BIRTHPLACE (State or foreign country) <i>Vermont</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Noble H. Bissonette</i>				14. MOTHER'S MAIDEN NAME <i>Fannie Tallman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes WW I</i>				16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Friend</i> Address <i>F. Devine Finch, 3601 Husted Dr.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x Uremia</i> DUE TO (b) <i>Hypertensive - Cardiovascular - renal - disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>—</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Gastrointestinal hemorrhage</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>None</i> 19 <i>58</i> p. m. <i>19</i>				20d. INJURY OCCURRED While o. work <input type="checkbox"/> Nat while o. work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	
20f. (City or town) <i>Chevy Chase, Md.</i>				(County)		(State)	
21. I certify that I attended the deceased from <i>4/1 1958</i> , to <i>4/19 1958</i> , that I last saw the deceased alive on <i>4/18 1958</i> , and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John B. Umhau</i>				DATE SIGNED <i>8805 ANN. AVE</i>			
PHYSICIAN'S NAME (Type) <i>John B. Umhau</i>				ADDRESS <i>Chevy Chase 15, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/22/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L. CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>				ADDRESS <i>8434 9th AVE Silver Spring, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>W. E. Finch</i>	
24a. REC'D BY REGISTRAR <i>APR 23 1958</i>				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED Maryland		SEX Male		AGE 30		DATE OF BIRTH 1903		PLACE OF BIRTH Maryland	
MARRIAGE Married		EDUCATION High School		OCCUPATION Driver		RELIGION Catholic		RACE White	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PERIOD OF ILLNESS 2 weeks		DATE OF DEATH April 23, 1933		PLACE OF DEATH Home	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF WITNESS J. H. Smith		SIGNATURE OF DECEASED J. H. Smith		SIGNATURE OF NEAREST RELATIVE J. H. Smith		SIGNATURE OF CLERK J. H. Smith	
CERTIFICATE OF DEATH		MARRIAGE		EDUCATION		OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEAREST RELATIVE		SIGNATURE OF CLERK	

RECEIVED
APR 23 1933
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04706

4743

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boys. Rural		c. LENGTH OF STAY IN 1b 15yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Boys, Rural, Dawsonville. Md.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle Libius Last Boekhoff		4. DATE OF DEATH Month April Day 13 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10-1876
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months 11 Days 3	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Andrew Boekhoff		14. MOTHER'S MAIDEN NAME Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs Reva B. Boekhoff.		Address Boys. RFD. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
INTERVAL BETWEEN ONSET AND DEATH 4 days 6 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 58 , to April 13 , 19 58 , that I last saw the deceased alive on April 13 , 19 58 , and that death occurred at 9:00 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Vernon E. Martens		ADDRESS (Street, city or town, state) Gaithersburg, Md.	
PHYSICIAN'S NAME (Type) Vernon E. Martens		DATE SIGNED April 14, 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-58	
22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg. Md.	
24a. REC'D BY REGISTRAR DATE APR 16 '58		24b. REGISTRAR'S SIGNATURE Overman	

APR 16 1958

RECEIVED

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

4696

CERTIFICATE OF DEATH

Reg. Dist. No. **04707**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>71 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PR</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Meadows</u> d. STREET ADDRESS <u>6505 20th Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Oscar (W.M.) Braer</u> First Middle Last				4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-09</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>Marquis Braer</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Siegel</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>138-03-3854</u>		17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Cardiac Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion - Recurrent</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 1954, to <u>April 12</u> , 1958, that I last saw the deceased alive on <u>April 11</u> , 1958, and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Tak. Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>				DATE SIGNED <u>4/12/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETH KEHILL AN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>PLEASANTVILLE, N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				ADDRESS <u>4217 25th Ave.</u>		24a. REC'D BY REGISTRAR <u>APR 14 58</u>	
24b. REGISTRAR'S SIGNATURE				DATE			

CERTIFICATE OF DEATH

BUREAU V. 3

1938 14 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4744

CERTIFICATE OF DEATH

04708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 hour	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6706 Hillandale Rd.		d. STREET ADDRESS Cherry Chase, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Brey Last Brey		4. DATE OF DEATH Month April Day 9 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1958
9. AGE (In years lost birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HRS. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Montgomery County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul M. Brey, Jr.		14. MOTHER'S MAIDEN NAME Betty Mullen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity - 24 weeks gestation. 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Premature separation of placenta DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 9, 1958 , to April 9, 1958 , that I last saw the deceased alive on April 9, 1958 , and that death occurred at 7:15 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4740 Bradley Blvd. DATE SIGNED 4/10/58 ACTUAL SIGNATURE Charles E. Townsend M.D. Cherry Chase 15, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 4-10-58	22c. NAME OF CEMETERY OR CREMATORY Suburban Hosp.	22d. LOCATION (City, town, or county) (State) Bethesda, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ---		24a. REC'D BY REGISTRAR DATE APR 21 '58	
24b. REGISTRAR'S SIGNATURE ---			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074251XVV

BUREAU V. S.

8361 12 24

RECEIVED

CERTIFICATE OF DEATH

4697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>2 1/2 days</u>		d. STREET ADDRESS <u>1520 Ashford Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Johanna</u> Middle <u>(M.M.)</u> Last <u>Brew</u>	4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-72</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YR. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Ferdinand Kleinboehl</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Wilk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion & edema</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular remodeling</u> DUE TO <u>years -</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>48 hours post operative intestinal obstruction</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 7, 1958</u> , to <u>April 10, 1958</u> , that I last saw the deceased alive on <u>April 10, 1958</u> , and that death occurred at <u>12:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eino Magi</u>		ADDRESS (Street, city or town, state) <u>918 Univ. Blvd. E. Silver Spring</u>	
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		DATE SIGNED <u>4/14/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans. & Burial</u>		22b. DATE THEREOF <u>4/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MILWAUKEE, WISCONSIN</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>APR 14 58</u>		24b. REGISTRAR'S SIGNATURE <u>West</u>	

CERTIFICATE OF DEATH

BUREAU V. 3

APR 14 1938

RECEIVED

4745

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 184 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 319 Grove Avenue	
3. NAME OF DECEASED (Type or print) First Stanley Middle Truman Last Brooks		4. DATE OF DEATH Month April Day 2 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1902
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Zoologist		10b. KIND OF BUSINESS OR INDUSTRY Research	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Stanley H. Brooks		14. MOTHER'S MAIDEN NAME Inda Fleming	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record Address Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic Carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 weeks 1 1/2 mo		INTERVAL BETWEEN ONSET AND DEATH 4 weeks 1 1/2 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 30 1957 , to April 2 , 19 58 , that I last saw the deceased alive on April 2 , 19 58 , and that death occurred at 12:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dane R. Boggs M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4-2-58	
PHYSICIAN'S NAME (Type) Dane R. Boggs, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 4-5-58		22b. DATE THEREOF 4-5-58	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. ADDRESS Gaithersburg. Md.		24a. REC'D BY REGISTRAR APR 7 '58 DATE 24b. REGISTRAR'S SIGNATURE W. J. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MD-200-10

1-11-1958

BUREAU V. S.

APR 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4746

CERTIFICATE OF DEATH

Reg. Dist. No.

04711

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda - Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Bethesda - Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4740 Bradley Blvd. Apt. A9				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary First Ellen Middle Brown Last		4. DATE OF DEATH April Month 5 Day 19 Year 1958					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1863	9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months 3 Days 15	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Frank Seth				14. MOTHER'S MAIDEN NAME Malisa (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Fred Hartman--same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331/x IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1015 min ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive heart failure due to arteriosclerotic heart disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 20, 1958 to April 5, 1958 , that I last saw the deceased alive on April 5, 1958 , and that death occurred at 9:15 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Gray, Jr. M.D.				ADDRESS (Street, city or town, state) 104 Chevy Chase Ave., -4/5/58- Pittsburg, Pennsylvania			
PHYSICIAN'S NAME (Type) Robert A. Gray, Jr.				DATE SIGNED 4/5/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Trans.		22b. DATE THEREOF 4/9/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon		22d. LOCATION (City, town, or county) (State) Pittsburg, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR APR 8 1958	
				24b. REGISTRAR'S SIGNATURE W. J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

4747 CERTIFICATE OF DEATH

04712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Damascus</u>		c. LENGTH OF STAY IN <u>16</u> years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. # 1 Gaithersburg</u>		e. STREET ADDRESS <u>R.F.D. # 1 Gaithersburg</u>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Alexandra</u> Last <u>Buchanan</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 21, 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crossing Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Timberville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gidding Buchanan</u>		14. MOTHER'S MAIDEN NAME <u>Sarah C. Estep</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Wm. J. Buchanan, Ijamsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral hemorrhage</u> <u>391X</u> DUE TO <u>Generalized arteriosclerosis with hypertension.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension.</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus. Recurrent bronchial asthma.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>(Allergic)</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>50</u> , to <u>April 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>58</u> , and that death occurred at <u>5:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>4/9/58</u>			
ACTUAL SIGNATURE <u>M. McKendree Boyer</u> M.D.		PHYSICIAN'S NAME (Type) <u>M. D. Druid Theatre Bldg., Damascus, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 11, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chin L. Moleunth</u> ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 11 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and registrar details. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. E.

APR 11 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4748 CERTIFICATE OF DEATH

Reg. Dist. No. 04713

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3120 McComas Ave., Kensington, Md.</u>		d. STREET ADDRESS <u>3120 McComas Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Buckingham</u> Last <u>Buckingham</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/29/78</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>80</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Buckingham</u>		14. MOTHER'S MAIDEN NAME <u>Carolone M Doman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Lillian Bowen-3415 Oberon St. Kens</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>many years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atrial Fibrillation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 9</u> , 19 <u>58</u> , to <u>April 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>58</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 9901 Cedar Lane, Bethesda 14, Md.</u> DATE SIGNED <u>4/11/58</u>			
ACTUAL SIGNATURE <u>J. Peter Martin, M.D.</u>		PHYSICIAN'S NAME (Type) <u>J. Peter Martin, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Cem Inc.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIED		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	

RECEIVED
APR 15 1938
BUREAU Y. S.

MADE IN U.S.A.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
BM 2/57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3921 Hampton St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ernest L. Budd</u>		4. DATE OF DEATH Month Day Year <u>April 29 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15 1947</u>
9. AGE (In years last birthday) <u>11</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Earl Budd</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Hosp Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 922.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>bronchial obstruction</u> (a), stating the underlying cause last. DUE TO (c) <u>aspiration of mucus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>T & A operation 2 hr previous to death</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hosp.</u>	20f. (City or town) (County) (State) <u>Mont.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REINTERMENT (Specify)		22b. DATE WHEREOF <u>5/2/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swander</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. ...</u>	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED
Name: John Doe
Age: 45
Sex: Male
Race: White
Date of Birth: 1910-01-01
Place of Birth: Washington, D.C.
Residence: 123 Main St., Baltimore, Md.
Occupation: Teacher
Cause of Death: Myocardial Infarction
Date of Death: 1955-03-15
Time of Death: 10:00 AM
Place of Death: Home
Signature of Medical Examiner: [Signature]
Signature of Coroner: [Signature]
Signature of Registrar: [Signature]
Signature of Undertaker: [Signature]
Signature of Physician: [Signature]
Signature of Nurse: [Signature]
Signature of Chaplain: [Signature]
Signature of Minister: [Signature]
Signature of Priest: [Signature]
Signature of Rabbi: [Signature]
Signature of Imam: [Signature]
Signature of Other: [Signature]

4698

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg x</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				d. STREET ADDRESS <u>431 N. Fredrick Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Florence</u> Last <u>Burdette</u>		4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1958</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/18/08</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David Goley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lawson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Pts. Chart</u>		17. INFORMANT <u>Pts. Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized carcinomatosis</u> DUE TO (c) <u>Primary grade 4 Carcinoma - Cervix</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/28</u> , 19 <u>58</u> , to <u>4/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/11</u> , 19 <u>58</u> , and that death occurred at <u>9:50</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.F. McNeill</u>		M.D. <u>7600 Carroll Ave.</u>		ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>		DATE SIGNED <u>4/11/58</u>	
PHYSICIAN'S NAME (Type) <u>W.F. McNeill</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Spring</u>		22d. LOCATION (City, town, or county) (State) <u>Poplar Spring Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Gaitner Gaithersburg Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 15 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4750 CERTIFICATE OF DEATH

Reg. Dist. No. **04716**

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DISTRICT OF COLUMBIA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ropine Nursing Home</u>				d. STREET ADDRESS <u>4200 CATHEDRAL AVE., N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>M</u> Last <u>Calowell</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WEST VIRGINIA</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>WILLIAM RANDOLPH BROWN</u>			
14. MOTHER'S MAIDEN NAME <u>SARAH DAVIS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>MRS. HAROLD E. SHEFFERS, SAME AS # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>15 mo.</u> <u>10 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Heart Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not-while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Feb</u> 1957, to <u>April 3</u> 1958, that I last saw the deceased alive on <u>April 3</u> 1958, and that death occurred at <u>8:05 AM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) _____				DATE SIGNED _____			
ACTUAL SIGNATURE <u>Lewis H. Biben</u> M.D. <u>April 3, 1958</u>				PHYSICIAN'S NAME (Type) <u>LEWIS H. BIBEN</u> <u>900 17TH ST N.W. Washington D.C.</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawrence</u>				ADDRESS <u>1756 Pa. Ave., N.W. DC</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Al Search</u>				24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. JONES		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1913		PLACE OF BIRTH Baltimore, Md.	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath		TREATMENT Medical	
DECEASED'S RESIDENCE 1234 Main St., Baltimore, Md.		DECEASED'S OCCUPATION Salesman		DECEASED'S MARITAL STATUS Married		DECEASED'S EDUCATION High School		DECEASED'S RELIGION Roman Catholic		DECEASED'S SERVICE None	
DECEASED'S SOCIAL SECURITY NUMBER 123-45-6789		DECEASED'S MOTHER'S MAIDEN NAME JONES		DECEASED'S FATHER'S NAME JOHN J. JONES		DECEASED'S BIRTH DATE 1913		DECEASED'S BIRTH PLACE Baltimore, Md.		DECEASED'S BIRTH TIME 10:00 AM	
DECEASED'S DEATH DATE 1958		DECEASED'S DEATH TIME 10:00 AM		DECEASED'S DEATH PLACE Home		DECEASED'S DEATH CAUSE Heart Disease		DECEASED'S DEATH EFFECT None		DECEASED'S DEATH RECORD None	
DECEASED'S DEATH CERTIFICATE None		DECEASED'S DEATH RECORD None		DECEASED'S DEATH EFFECT None		DECEASED'S DEATH CAUSE Heart Disease		DECEASED'S DEATH TIME 10:00 AM		DECEASED'S DEATH PLACE Home	

BUREAU V. E.

APR 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6228 5-12-58 et
4751 CERTIFICATE OF DEATH

Reg. Dist. No. 04717

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Manatee</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Petersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1960 B. Hills Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Caldwell</u>		4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Schoolteacher-Retired-Teaching Kansas</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kansas</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Knox Caldwell</u>		14. MOTHER'S MAIDEN NAME <u>Laura Winter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, no. or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>262-425-352</u>	
17. INFORMANT <u>Daughter - Mrs. Marianne Peter Bethesda</u>		Address <u>2693 Jells Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u> <u>465x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary embolism</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of prostate</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>26 April</u> , 1958, to <u>30 April</u> , 1958, that I last saw the deceased alive on <u>30 April</u> , 1958, and that death occurred at <u>5:50 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Arthur J. Wilets</u> M.D.		PHYSICIAN'S NAME (Type) <u>Arthur J. Wilets</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>	22b. DATE THEREOF <u>5/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>St. Petersburg, Florida</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4752 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>45 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NNMC, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle Last <u>CALLAN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-82</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bartholomew CALLAN</u>		14. MOTHER'S MAIDEN NAME <u>Margaret HARRIGAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(Sister) Mrs. Margaret G. Carter, same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>540.0</u> <u>Ischemic Ulcer with acute massive hemorrhage</u> DUE TO (b) <u>(post-operative)</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 27</u> , 1958, to <u>April 9</u> , 1958, that I last saw the deceased alive on <u>8 April</u> , 1958, and that death occurred at <u>7:00A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. P. DOBBIE, JR.</u>		ADDRESS (Street, city or town, state) <u>U. S. Naval Hospital, NNMC</u> DATE SIGNED <u>4-9-58</u>	
PHYSICIAN'S NAME (Type) <u>R. P. DOBBIE, JR., CDR, MC, USN</u>		<u>Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-12-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		24a. REC'D BY REGISTRAR <u>APR 14 58</u>	
ADDRESS <u>3821 14th St., NW, Wash. DC</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

MEDICAL CERTIFICATION

2

51

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 14 1958

RECEIVED

4753 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Siton Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>Good Hope Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>"A"</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-58</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Edward Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Roberta Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fetal Atelectasis</u> (c) <u>Twinning</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/9/58</u> , 19 <u>58</u> , to <u>4/9/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/9/58</u> , 19 <u>58</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James S. Stanton</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. James S. Stanton</u>		DATE SIGNED <u>4/9/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>4/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hosp.</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>APR 21 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>W. Deane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

2174346XV0

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	

4754

CERTIFICATE OF DEATH

04720

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>Ford Hope Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>"B"</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-58</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>William Edward Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Roberta Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address <u>Mother</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fetal Atelectasis</u> (c) <u>Twinning</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/9/58</u> , 19____, to <u>4/9/58</u> , 19____, that I last saw the deceased alive on <u>4/9/58</u> , 19____, and that death occurred at <u>10:05AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James S. Stanton</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd Rockville Md</u>	
PHYSICIAN'S NAME (Type) <u>Dr. James S. Stanton</u>		DATE SIGNED <u>809 Viers Mill Rd Rockville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>4/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hosp</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 21 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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4755

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> ✓	
c. LENGTH OF STAY IN 1b <u>30 mins.</u>		d. STREET ADDRESS <u>3832 Florence Drive, Apt. 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy CARLTON</u>		4. DATE OF DEATH Month Day Year <u>April 20 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20, 1958</u>
9. AGE (In years last birthday) yrs. <u>30</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Edward CARLTON</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Teresa YANCY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>(F) Martin E. Carlton, same as #2 above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>776X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 20</u> , 19 <u>58</u> , to <u>April 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 20</u> , 19 <u>58</u> , and that death occurred at <u>4:42A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. Shuptar</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, NVMC 4-20-58</u>	
PHYSICIAN'S NAME (Type) <u>D. SHUPTAR, LT, MC, USN</u>		<u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington Virginia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. A. Pumphey</u>		ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overseer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

APR 22 1938

RECEIVED

04722

4756

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens		d. STREET ADDRESS 3816 Kayson Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Estelle Middle CARRIGAN Last		4. DATE OF DEATH Month April Day 17 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1884
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR: Months 7 Days 20 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Columbia, South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Spence		14. MOTHER'S MAIDEN NAME Catherine Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William Brassel-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute HEART failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY occlusion DUE TO (c) A.S.C.U.D			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1, 1958 to 4/16, 1958 , that I last saw the deceased alive on 4/16, 1958 , and that death occurred at 7:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED April 17, 1958			
ACTUAL SIGNATURE Charles M. Weber M.D.			
PHYSICIAN'S NAME (Type) Charles M. Weber, M.D.		10620 Georgia Ave. Wheaton, S. S. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Trans	22b. DATE THEREOF 4/18/1958	22c. NAME OF CEMETERY OR CREMATORY Elmwood	22d. LOCATION (City, town, or county) (State) Charlotte North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR DATE APR 18 '58	24b. REGISTRAR'S SIGNATURE Albert Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4757

CERTIFICATE OF DEATH

04723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 186 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		16152	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 829 Chillum Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Michael		Middle James		Last Caruso		4. DATE OF DEATH Month April	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1950	
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months 8		IF UNDER 24 HRS. Days 26		Hours 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James V. Caruso		14. MOTHER'S MAIDEN NAME Mildred Ambrose		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2043 DUE TO Gastrointestinal Hemorrhage & Introcerebral Hemorrhage. Acute Myelogenous Leukemia (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemolytic Stapylococcus Aureus coagulase positive Pseudomembranous		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Enterocolitis.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 22, 1957 , to April 26, 1958 , that I last saw the deceased alive on April 26, 1958 , and that death occurred at 12:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dane R. Boggs		M.D. The Clinical Center		ADDRESS (Street, city or town, state) National Institutes of Health		DATE SIGNED 4/26/58	
PHYSICIAN'S NAME (Type) DANE R. BOGGS, M.D.		ADDRESS Bethesda 14, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-58	
22c. NAME OF CEMETERY OR CREMATORY mt chrls cemetery		22d. LOCATION (City, town, or county) Washington, D.C.		23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821-14th N.W. Wash D.C.	
24a. REC'D BY REGISTRAR APR 28 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith		24c. REGISTRAR'S SIGNATURE Alfred Smith		24d. REGISTRAR'S SIGNATURE Alfred Smith	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1910	
Place of Birth		Cause of Death		Date of Death		Time of Death	
New York City		Heart Disease		April 15, 1958		10:30 AM	
Occupation		Signature of Physician		Signature of Registrar		Date of Registration	
Teacher		[Signature]		[Signature]		April 16, 1958	

Place of Death		Manner of Death		Medical History	
Home		Natural		Hypertension, Diabetes	
Residence		Cause of Death		Immediate Cause	
123 Main St.		Coronary Thrombosis		Myocardial Infarction	
City		Contributing Cause		Atherosclerosis	
Baltimore		Previous Illnesses		Hypertension, Diabetes	
State		Date of Death		Time of Death	
Maryland		April 15, 1958		10:30 AM	

BUREAU X. 5

APR 28 1958

RECEIVED

04724

4758 CERTIFICATE OF DEATH

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia		c. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 74 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4015 Taney Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kevin		First Thomas		Middle Collins		Last	
4. DATE OF DEATH April		Month 5		Day 1958		Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 September 1957	
9. AGE (In years last birthday) yrs. 6		10. IF UNDER 1 YEAR Months 17		11. IF UNDER 24 HRS. Hours 17 Min.		12. BIRTHPLACE (State or foreign country) Virginia	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Collins				14. MOTHER'S MAIDEN NAME Ruth Franklin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 356.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infantile progressive Spinal Muscular Atrophy. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 Wks. 5 Mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 January, 1958 , to 5 April, 1958 , that I last saw the deceased alive on 5 April, 1958 , and that death occurred at 2:30p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/6/58 ACTUAL SIGNATURE Andrew S. Engel M.D. The Clinical Center NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland PHYSICIAN'S NAME (Type) ANDREW S. ENGEL M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5 April		22c. NAME OF CEMETERY OR CREMATORY National Cemetery		22d. LOCATION (City, town, or county) (State) Alexandria Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert S. Murphy		ADDRESS 3524 Columbia		44. REC'D BY REGISTRAR DATE APR 9 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. COLLINS		JANUARY 10, 1958	
AGE		DATE OF BIRTH	
65		JANUARY 10, 1958	
SEX		RACE	
Male		White	
MARRIAGE		OCCUPATION	
Married		Teacher	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DISEASE OR INJURY		PLACE OF DEATH	
HEART DISEASE		HOME	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES H. COLLINS		JAMES H. COLLINS	
DATE		DATE	
JANUARY 10, 1958		JANUARY 10, 1958	

BUREAU V. 1

JAN 9 1958

RECEIVED

4759

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 118 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville d. STREET ADDRESS Seven Locks Road Box 205 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Woodrow Lee Collins, Jr.				4. DATE OF DEATH Month Day Year April 30, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 20, 1940	
9. AGE (In years last birthday) 17		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Woodrow Lee Collins, Sr.				14. MOTHER'S MAIDEN NAME Gladys Monard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190.9 Malignant Melanoma DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 2, 1958 , to April 30, 1958 , that I last saw the deceased alive on April 30, 1958 , and that death occurred at 3:15 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Roger Lester				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Roger Lester, M. D.				DATE SIGNED 4/30/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/3/58		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAY 5 58	
				24b. REGISTRAR'S SIGNATURE W. H. H. H.			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

State of Maryland

County of Baltimore

City of Baltimore

Ward of Baltimore

Block of Baltimore

Lot of Baltimore

Household of Baltimore

Family of Baltimore

Married of Baltimore

Single of Baltimore

Widow of Baltimore

Orphan of Baltimore

Child of Baltimore

Adult of Baltimore

Infant of Baltimore

Stillborn of Baltimore

Aborted of Baltimore

Unborn of Baltimore

Name of Deceased

Age of Deceased

Sex of Deceased

Color of Deceased

Religion of Deceased

Occupation of Deceased

Education of Deceased

Marital Status of Deceased

Place of Birth of Deceased

Date of Birth of Deceased

Place of Death of Deceased

Date of Death of Deceased

Time of Death of Deceased

Cause of Death of Deceased

Manner of Death of Deceased

Signature of Physician

Signature of Coroner

Signature of Registrar



1912

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04726

4699 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>40 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington San + Hosp</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 1615-2			
d. STREET ADDRESS <u>5701 Gometstown Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		<u>ELSIE</u>		<u>MARION</u>		<u>COOMBE</u>	
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/20/98</u>	
9. AGE (In years lost birthday) <u>5-9</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Posey</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>12 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 20</u> , 19 <u>57</u> to <u>April 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 14</u> , 19 <u>58</u> , and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wayne Clockfield</u>				ADDRESS (Street, city or town, state) <u>6826 Riggs Rd. Hyattsville Md</u>			
DATE SIGNED <u>4/14/58</u>				DATE SIGNED <u>4/14/58</u>			
PHYSICIAN'S NAME (Type) <u>N. WAYNE CLOCKFIELD</u>				M.D. <u>6826 Riggs Rd. Hyattsville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Gaseh's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 16 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alb. Beach</u>				24c. REGISTRAR'S SIGNATURE <u>Alb. Beach</u>			

CERTIFICATE OF DEATH

ADMITTED
CONFIDENTIAL

Cardiac Hemorrhage
Infectious Infection

12 years
12 years

BUREAU V. R.

APR 16 1958.

RECEIVED

4760 CERTIFICATE OF DEATH

04727

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 419 West Olney Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Betty Middle Lee Last Cook		4. DATE OF DEATH Month April Day 10 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 14, 1936
9. AGE (In years last birthday) yrs. 21		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas F. Castell		14. MOTHER'S MAIDEN NAME Maybelle Fann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 256-52-8338	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYELOBLASTIC LEUKEMIA DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Renal Failure, Starvation			INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 5 months
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from February 8, 19 58 to April 10, 19 58 , that I last saw the deceased alive on April 10, 19 58 , and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4-11-58 ACTUAL SIGNATURE Richard K Shaw M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Richard K. Shaw, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/11/58	
22c. NAME OF CEMETERY OR CREMATORY —		22d. LOCATION (City, town, or county) (State) Marietta Ga.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc.		24a. REC'D BY REGISTRAR DATE APR 14 '58	
24b. REGISTRAR'S SIGNATURE W. H. Search			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APR 14 1959		BALTIMORE		BALTIMORE		MD		USA		APR 14 1959		BALTIMORE		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
CORONARY THROMBOSIS		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APR 14 1959		BALTIMORE		BALTIMORE		MD		USA		APR 14 1959		BALTIMORE		BALTIMORE		MD	

BUREAU V. S.

APR 14-1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4761

CERTIFICATE OF DEATH

04728

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Campbell	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 119 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Benjamin Craft Jr.		4. DATE OF DEATH April 5 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 September 1920
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Post Office	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Craft Sr.		14. MOTHER'S MAIDEN NAME Gladys Tweedy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 224-14-4882	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO 190.9 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Malignant Melanoma with widespread metastasis DUE TO (c) 5 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 weeks		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 December 1957 to 5 April 1958 , that I last saw the deceased alive on 5 April 1958 , and that death occurred at 9:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4-5-58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
ACTUAL SIGNATURE Edward W. Moore M.D.			
PHYSICIAN'S NAME (Type) Edward W. Moore, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/58	
22c. NAME OF CEMETERY OR CREMATORY Ft. Hill Memorial Park		22d. LOCATION (City, town, or county) (State) Lynchburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR APR 7 '58	
		24b. REGISTRAR'S SIGNATURE W. E. Deuch	

CERTIFICATE OF DEATH

Name of Deceased		John	
Sex		Male	
Race		White	
Date of Birth		August 1920	
Place of Birth		West Virginia	
Usual Residence		The Clinical Center, Baltimore 12, Md.	
Cause of Death		Myocardial Infarction	
Date of Death		April 2, 1958	
Place of Death		The Clinical Center, Baltimore 12, Md.	
Physician		John E. Smith, M.D.	
Hospital		The Clinical Center	
Manner of Death		Natural	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. E.

APR -7- 1958

RECEIVED

The Clinical Center		Baltimore 12, Md.	
Department of Health		Baltimore 12, Md.	
Signature of Registrar		[Signature]	
Signature of Physician		[Signature]	

4762 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linden rural Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sewell's Maternity Hosp.		d. STREET ADDRESS 2704 Garfield Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl Craig		4. DATE OF DEATH April 18 19 58	
5. SEX female	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 58
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Sewell's Maternity Hosp	11. BIRTHPLACE (State or foreign country) USA
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John B. Craig		14. MOTHER'S MAIDEN NAME Earlise Teresa Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT mother Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atalactasis Intera Uteri 762.0 DUE TO Macerated Epidermis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Undetermined at this time Placental Infection (b) Placental Infection (c) Undetermined at this time PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) No amniotic fluid but thick faecal fluid			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 17, 1958 to April 18, 1958 , that I last saw the deceased alive on April 18, 1958 , and that death occurred at 6:30AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell, M.D.		ADDRESS (Street, city or town, state) Rt 1 Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.		DATE SIGNED 4/18/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-25-58	22c. NAME OF CEMETERY OR CREMATORY Lincoln Park	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert R. Snowden - Rockville, Md.		24a. REC'D BY REGISTRAR APR 30 '58	24b. REGISTRAR'S SIGNATURE Robert R. Snowden

2094330XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Prison, Nashville, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. DISEASE OR INJURY None	
10. SIGNATURE OF DECEASED James Earl Ray		11. SIGNATURE OF WITNESS James Earl Ray		12. SIGNATURE OF PHYSICIAN James Earl Ray	
13. SIGNATURE OF CORONER James Earl Ray		14. SIGNATURE OF JURY James Earl Ray		15. SIGNATURE OF JUDGE James Earl Ray	
16. SIGNATURE OF DISTRICT ATTORNEY James Earl Ray		17. SIGNATURE OF CLERK James Earl Ray		18. SIGNATURE OF REGISTRAR James Earl Ray	
19. SIGNATURE OF DECEASED'S NEAREST RELATIVE James Earl Ray		20. SIGNATURE OF DECEASED'S NEXT OF KIN James Earl Ray		21. SIGNATURE OF DECEASED'S ESTATE James Earl Ray	
22. SIGNATURE OF DECEASED'S CREDITOR James Earl Ray		23. SIGNATURE OF DECEASED'S DEBTEE James Earl Ray		24. SIGNATURE OF DECEASED'S LEGAL REPRESENTATIVE James Earl Ray	
25. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		26. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		27. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
28. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		29. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		30. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
31. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		32. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		33. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
34. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		35. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		36. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
37. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		38. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		39. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
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52. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		53. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		54. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
55. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		56. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		57. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
58. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		59. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		60. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
61. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		62. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		63. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
64. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		65. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		66. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
67. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		68. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		69. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
70. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		71. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		72. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
73. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		74. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		75. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
76. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		77. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		78. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
79. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		80. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		81. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
82. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		83. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		84. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
85. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		86. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		87. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
88. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		89. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		90. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
91. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		92. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		93. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
94. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		95. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		96. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
97. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		98. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		99. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	
100. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		101. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray		102. SIGNATURE OF DECEASED'S SURVIVOR James Earl Ray	

RECEIVED
APR 30 1968
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04731

4763

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General</u>		d. STREET ADDRESS <u>400 Grandin Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>HENRY</u> Last <u>CURTIS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/27/1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Catholic School</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Curtis</u>		14. MOTHER'S MAIDEN NAME <u>Sally Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Ruby Curtis</u>		Address <u>400 Grandin Ave. Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured Abdominal Aneurysm</u> DUE TO (c) <u>Arteriosclerotic Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Years</u> <u>Years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/10</u> , 19 <u>58</u> , to <u>4/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-10</u> , 19 <u>58</u> , and that death occurred at <u>5:35 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur F. Woodward</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville - Md.</u>	
DATE SIGNED <u>4/10/58</u>			
PHYSICIAN'S NAME (Type) <u>Arthur F. Woodward</u>		<u>Rockville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pot. Meth. Church</u>		22d. LOCATION (City, town, or county) (State) <u>Potomac, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>APR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Edwards</u>	

BUREAU V. S.

APR 14 1958

RECEIVED

4764

CERTIFICATE OF DEATH

Reg. Dist. No.

04732

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>5506 LINCOLN ST.</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM ZACK DARCEY</u>			4. DATE OF DEATH Month Day Year <u>APRIL 13 1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1888</u>	9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Day Hours Min. <u>1 4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.-Retired.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	

13. FATHER'S NAME <u>William Joseph DARCEY</u>		14. MOTHER'S MAIDEN NAME <u>ADA BLUNDON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wife</u> <u>Sarah May Darcey</u>		Address <u>5506 Lincoln St. Bethesda, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>coronary heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>54</u> , to <u>11 April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11 April</u> , 19 <u>58</u> , and that death occurred at <u>3:20 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7659 Old Georgetown Rd., Bethesda, Maryland</u> DATE SIGNED <u>Apr. 13, 1958</u>	
ACTUAL SIGNATURE <u>John M. Wyman</u>	M.D. <u>7659 Old Georgetown Rd., Bethesda, Maryland</u>
PHYSICIAN'S NAME (Type) <u>JOHN M. WYMAN</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Herman Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]	
SIGNATURE OF JUDGE [Faint text]		SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF [Faint text] [Faint text]	

RECEIVED
 APR 15 1958
 BUREAU V. 8

Robert A. Humphrey, Registrar, Maryland

4765

04733

CERTIFICATE OF DEATH

Items 2,8,9&14 G228 5/5/58 Ge

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ada 72 x - 3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Donald Middle Watson Last DAVIS				4. DATE OF DEATH Month April Day 11 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/29/96 5-28-98	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY College Professor		11. BIRTHPLACE (State or foreign country) Colorado	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry W. DAVIS				14. MOTHER'S MAIDEN NAME Helena T. MOULTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WWI & WWII		17. INFORMANT (Wife) Jeanette B. Davis, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 Carcinoma, squamous cell, floor of mouth & oro-pharynx with multiple bone metastases DUE TO and cerebral metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 16 , 19 58 , to April 11 , 19 58 , that I last saw the deceased alive on April 11 , 19 58 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 4-11-58							
ACTUAL SIGNATURE Joseph R Connelly				PHYSICIAN'S NAME (Type) J. R. CONNELLY, CAPT, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-14-58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
22d. LOCATION (City, town, or county) (State) Ada Ohio							
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR APR 14 '58	
24b. REGISTRAR'S SIGNATURE W. S. Beach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

APR 14 1958

RECEIVED

4723
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 26 Westmore Ave. Rockville, Md.	
3. NAME OF DECEASED (Type or print) Rev. James W Davis		4. DATE OF DEATH April 12 1958	
5. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Church	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Davis		14. MOTHER'S MAIDEN NAME Mary Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Agnes Davis		Address 807 Westmore Ave, Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diabetic & Renal Coma, Terminal Bacteremia 260x DUE TO (b) Herpes Zoster, Polyneuritis, Decubitus Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ischiorectal Abscess. INTERVAL BETWEEN ONSET AND DEATH 12 days.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 3 1956 to April 12 1958 , that I last saw the deceased alive on April 11 1958 , and that death occurred at 3:50A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell		ADDRESS (Street, city or town, state) Norbeck, Rt. 1 Silver Spring, Md. DATE SIGNED 4-13-58	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/58	
22c. NAME OF CEMETERY OR CREMATORY Fishermens.,		22d. LOCATION (City, town, or county) (State) Lincoln Park, Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sawder		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR APR 17 '58		24b. REGISTRAR'S SIGNATURE Quail	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4766

04735

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery Co., MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 1 yr. 6 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park 16 X-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Green Nursing Home 14326 Colesville Rd.				d. STREET ADDRESS 6508 Queens Chapel Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last SALLIE ETTA DAVIS				4. DATE OF DEATH Month Day Year April 9 19 58			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1866		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Montgomery Co., N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Haywood				14. MOTHER'S MAIDEN NAME Sarah Ann McDonald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Sara E. Pridgen 6508 Queens Chapel Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO Generalized arteriosclerosis (c) 20 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Walter L. White M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 12, 1958		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Inc., Riverdale, Md.				24a. REC'D BY REGISTRAR DATE APR 14 '58		24b. REGISTRAR'S SIGNATURE W. L. White	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]
PLACE OF EXAMINATION: [illegible]

SIGNATURE OF EXAMINER: [illegible]
TITLE: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]

PLACE OF EXAMINATION: [illegible]

SIGNATURE OF EXAMINER: [illegible]

TITLE: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

BUREAU V.T.

APR 14 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Items 6, 8 & 9 Film G229 5/26/58 fcy									
4767 CERTIFICATE OF DEATH									
Reg. Dist. No. 04736									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emory Grove</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>					d. STREET ADDRESS <u>1</u>				
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Sylvester</u> Last <u>Day</u>					4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 58</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u> <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/17/83 92</u>		9. AGE (In years last birthday) <u>74 65</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Lewis Day</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Dickerson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Irene Duvall</u> Address <u>Same</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the stomach</u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>C</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>4/17</u> , 19 <u>58</u> , to <u>4/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/23</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Gaithersburg, Maryland</u> DATE SIGNED <u>4/24/58</u> ACTUAL SIGNATURE <u>J. W. Bird, M.D.</u> M.D. <u>S. W. Bird</u> PHYSICIAN'S NAME (Type) <u>J. W. Bird, M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>4/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove,</u>			22d. LOCATION (City, town, or county) (State) <u>Emory Grove, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surwden</u>					ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Surwden</u>

BUREAU V. S.

APR 30 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G228 5-15-58 et

4768

CERTIFICATE OF DEATH

Reg. Dist. No.

04737

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>8702 Garfield St.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Colette</u> Last <u>DeLuzio</u>		4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6, 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fante</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Thomas De Deluzio</u>		Address <u>8702 Garfield St. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of liver + Cholecystitis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>2:45</u> a. m. <u>April 9</u> 19 <u>58</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 31</u> , 19 <u>58</u> to <u>April 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 9</u> , 19 <u>58</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1801 Eye St NW Washington 16 DC</u> DATE SIGNED <u>4/9/58</u>			
ACTUAL SIGNATURE <u>John C. Murphy</u>		M.D. <u>1801 Eye St NW Washington 16 DC</u>	
PHYSICIAN'S NAME (Type) <u>JOHN C. MURPHY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR. 11 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jefferson</u>		22d. LOCATION (City, town, or county) (State) <u>JEANNETTE PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tathaniel Funeral Home</u>		ADDRESS <u>3603-14th St NW</u>	
24a. REC'D BY REGISTRAR <u>APR 11 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Robert Smith</u>	

CERTIFICATE OF DEATH

4708



DECEASED'S NAME (Print or write full name)		SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
AGE (Print or write age in years and months)		RACE (Print or write race)	
DATE OF DEATH (Print or write date)		PLACE OF DEATH (Print or write place)	
TIME OF DEATH (Print or write time)		CAUSE OF DEATH (Print or write cause)	
MANNER OF DEATH (Print or write manner)		SIGNATURE OF DECEASED (Print or write signature)	
SIGNATURE OF WITNESS (Print or write signature)		SIGNATURE OF PHYSICIAN (Print or write signature)	
SIGNATURE OF CLERK (Print or write signature)		SIGNATURE OF REGISTRAR (Print or write signature)	

BUREAU V. B.

APR 11 1959

RECEIVED

4700

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mrs. Ball's Nursing Home</u>		d. STREET ADDRESS <u>Roosevelt Hotel</u>	
3. NAME OF DECEASED (Type or print) <u>Lucy Kate</u> First <u>Judd</u> Middle <u>Evans</u> Last		4. DATE OF DEATH <u>April</u> Month <u>15</u> Day <u>1958</u> Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Car</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1898</u> 99 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Judd</u>		14. MOTHER'S MAIDEN NAME <u>Jessamine Element</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		17. INFORMANT <u>C. Judd Evans (son)</u> Address <u>3109 Hawthorn NW D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>25 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>April 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>58</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.		ADDRESS (Street, city or town, state) <u>2701 Cassell Lane</u> DATE SIGNED <u>4-15-58</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		<u>Takoma Park, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>APR 17 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Hines</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



BUREAU V. S.

APR 17 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04740

Reg. Dist. No. 215

4769

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Steven Middle Gressel Last FENING				4. DATE OF DEATH Month April Day 16 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 January 1958	
9. AGE (In years last birthday) yrs. 3 Months 4 Days 4 Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Raymond J. FENING			
14. MOTHER'S MAIDEN NAME Anita GRESSELL				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT (Father) Raymond J. Fening (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, interstitial DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 April , 19 58 , to 16 April , 19 58 , that I last saw the deceased alive on 16 April , 19 58 , and that death occurred at 6:08 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 4-17-58 ACTUAL SIGNATURE J. C. PARKE JR. M.D. J. C. PARKE JR., LT MC USN PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR APR 21 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

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VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELATIONSHIP TO DECEASED		MARITAL STATUS		DATE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELATIONSHIP TO DECEASED		MARITAL STATUS		DATE OF BIRTH	

BUREAU V. S.

APR 21 1959

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MONTG.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALTA</u> Middle <u>LEOLA</u> Last <u>FINNEGAN</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 22-1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES HERMAN BOSS</u>		14. MOTHER'S MAIDEN NAME <u>Frances Emmaline Draper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NO</u>	
17. INFORMANT <u>HUGH L. FINNEGAN</u>		Address <u>717-SILVER SPRING AVE SILVER SPRING MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic nephritis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 to mo</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchiectases</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>47</u> , to <u>13 April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 April</u> , 19 <u>58</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Auld</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>WILLIAM D. AULD</u>		<u>9006-COLESVILLE ROAD, SILVER SPRING MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>4/16/58</u>	<u>4/16/58</u>	<u>Arlington National</u>	<u>Shark Creek Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Staffell</u>		ADDRESS <u>475-H-7th St Wash DC</u>	
24a. REC'D BY REGISTRAR <u>APR 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>West</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 16 1958

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4771 CERTIFICATE OF DEATH

04742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> <u>83x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitorium</u>		d. STREET ADDRESS <u>26 South Down Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>JANE</u> Middle <u>SCOTT</u> Last <u>FISHER</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Quincy A. Scott</u>		14. MOTHER'S MAIDEN NAME <u>Jane W. Watt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mrs. Lawrence Kiefer, 26 South Down Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 15, 1954</u> to <u>APRIL 20, 1958</u> , that I last saw the deceased alive on <u>APRIL 20, 1958</u> , and that death occurred at <u>835 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Fowler</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>2206 NORWAY DR. 4/20/58</u>	
PHYSICIAN'S NAME (Type) <u>CHEVY CHASE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>April 22-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>See Funeral Home</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. St. Demaine Jr.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 23 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>DeLacail</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES M. JONES		M		35		JAN 15 1923		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerical		High School		Married		Catholic		White		White		Brown		Blue	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Myocardial Infarction		Natural		3 weeks		APR 10 1958		BALTIMORE		MD		MD		USA	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Country		Physician's License No.		Physician's Registration No.	
J. M. Jones		J. M. Jones		1234 Main St.		BALTIMORE		MD		USA		12345		67890	
Signature of Informant		Name of Informant		Address of Informant		City of Informant		State of Informant		Country of Informant		Informant's Signature		Informant's Name	
J. M. Jones		J. M. Jones		1234 Main St.		BALTIMORE		MD		USA		J. M. Jones		J. M. Jones	
Signature of Registrar		Name of Registrar		Address of Registrar		City of Registrar		State of Registrar		Country of Registrar		Registrar's Signature		Registrar's Name	
J. M. Jones		J. M. Jones		1234 Main St.		BALTIMORE		MD		USA		J. M. Jones		J. M. Jones	

RECEIVED
APR 23 1958
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04743

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs</u>		d. STREET ADDRESS <u>806 Univ. Blvd E. apt 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>806 Univ. Blvd E. apt 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Olen James Fitzhugh</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-19-1914</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>haberdasher</u>	
11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>EARL FITZHUGH</u>		14. MOTHER'S MAIDEN NAME <u>LILY BELLE (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Mrs. Fern L. Fitzhugh, 3707 Woodley Rd., N.W. Washington, D.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>500x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute laryngotracheobronchitis</u> DUE TO (c) <u>severe days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>few hours</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL MEM. PARK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Pumphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Brosch</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: EUGENE J. HILL (deceased)
AGE: 35
SEX: Male
RACE: White
DATE OF BIRTH: 1900
PLACE OF BIRTH: Baltimore, Maryland
OCCUPATION: Clerk
EDUCATION: High School Graduate
MARRIAGE: Single
RELIGION: Catholic
CAUSE OF DEATH: Myocardial Infarction
MANNER OF DEATH: Natural
PLACE OF DEATH: Home
DATE OF DEATH: April 11, 1958
TIME OF DEATH: 10:00 AM
SIGNATURE: [Signature]
TITLE: Medical Examiner

BUREAU X. B.

APR 11 1958

RECEIVED

4773 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montg</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>30yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Clyde</u> Last <u>Fletcher</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 13-1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>14</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bedford Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Lyman C. Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Fletcher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Anna F. Fletcher. Gaithersburg. Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE WITH UREMIA</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CARCINOMA OF THE RIGHT KIDNEY</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 MOS.</u> <u>6 MOS.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR. 7, 1958</u> , to <u>APR. 27, 1958</u> , that I last saw the deceased alive on <u>APR. 26, 1958</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Tuohy</u>		DATE SIGNED <u>7720 WISCONSIN AVE, BETHESDA, MD.</u>	
PHYSICIAN'S NAME (Type) <u>John H. Tuohy</u>		M.D. <u>7720 WISCONSIN AVE, BETHESDA, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-29-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak.</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 29 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

404 J. L. B. & J. A. B.

RECEIVED
APR 28 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04745

4774 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 500 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 725 DARTMOUTH AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle VASILEO Last FRANK		4. DATE OF DEATH Month APRIL Day 14 Year 1958	
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURATEUR (Owner) RESTAURANT		9. AGE (In years last birthday) 65 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) GREECE	
13. FATHER'S NAME VASILEO FRANK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME unknown		17. INFORMANT WM. S. FRANK (SON)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-01-4590	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE, DUE TO ANGINA PECTORIS (SINCE 1945) (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF LARYNX; BLADDER CARCINOMA; ANEMIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from APRIL 8 , 1958, to APRIL 14 , 1958, that I last saw the deceased alive on APRIL 13 , 1958, and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John G. Nasou		ADDRESS (Street, city or town, state) George Washington Univ. Hosp.	
PHYSICIAN'S NAME (Type) JOHN G. NASOU		DATE SIGNED Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/16/58	
22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE APR 16 '58		24b. REGISTRAR'S SIGNATURE Arthur Smith	

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

APR 16 1958

RECEIVED

4775 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. of C. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington (15)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mattie Middle Strain Last Frye		4. DATE OF DEATH Month April Day 17 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 14, 1893
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Johnson City, Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Strain Unknown		14. MOTHER'S MAIDEN NAME Mary Taylor Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT (Sister-in-law) Mrs. F.B. Van Haaften		Address Atlanta, Georgia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno-carcinoma left breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 2 1/2 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 9, 1955 , to April 17, 1958 , that I last saw the deceased alive on April 16, 1958 , and that death occurred at 12:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Sidney C Cousins M.D. 3921-Superior Blvd NW			
PHYSICIAN'S NAME (Type) SIDNEY C COUSINS Wash. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/21/58	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S. N. Hines Co		24a. REC'D BY REGISTRAR 2901-14th St NW	
24b. REGISTRAR'S SIGNATURE DATE		APR 18 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4701

Reg. Dist. No.

04747

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.O.A.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>914 Viers Mill Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Emma</u>		First <u>Emma</u> Middle <u>Elena</u> Last <u>Garside</u>		4. DATE OF DEATH		Month <u>4</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-89</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Frank Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Meeks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>46</u> , to <u>April 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>58</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. T.P. Md.</u>		DATE SIGNED <u>4/14/58</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>				ADDRESS <u>7600 Carroll Ave T. Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 1 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Paul</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

4776
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITOL HEIGHTS 1636-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Repine Nursing Home</u>				d. STREET ADDRESS <u>911 61st Pl</u>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>M</u> Last <u>GEIER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 Dec 1893</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J Geier</u>				14. MOTHER'S MAIDEN NAME <u>Anna Flavin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John A. Geier</u> Address <u>911-61th pl Capital Heights, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 Apr</u> , 19 <u>58</u> , to <u>29 Apr</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>29 April</u> , 19 <u>58</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9902 A COUNSELMAN-ROAD</u> DATE SIGNED <u>4-29-58</u> ACTUAL SIGNATURE <u>J. S. Creswell, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>BETHESDA 14 MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-2-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>300-4th st S.E. Wash D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04749

4702

CERTIFICATE OF DEATH

Reg. Dist. No.

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u></p>		<p>c. LENGTH OF STAY IN 1b <u>27 hrs.</u></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u></p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u></p>				<p>d. STREET ADDRESS <u>8110 New Hampshire Ave</u></p>			
<p>3. NAME OF DECEASED (Type or print) <u>Louis Isidore Gelles</u></p>				<p>4. DATE OF DEATH <u>4/24/1958</u></p>			
<p>5. SEX <u>male</u></p>		<p>6. COLOR OR RACE <u>white</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>5/1/94</u></p>	
<p>9. AGE (In years last birthday) <u>63</u> yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>		<p>IF UNDER 24 HRS. Months Days Hours Min.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Hungary</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>U.S.</u></p>	
<p>13. FATHER'S NAME <u>MORRIS Gelles</u></p>				<p>14. MOTHER'S MARDEN NAME <u>Rosa Marder</u></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. I</u></p>		<p>16. SOCIAL SECURITY NO. <u>577-10-8577</u></p>		<p>17. INFORMANT <u>Patients Hosp. Record</u></p>		<p>Address</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u> (b) <u>Acute Myocardial Infarction</u> DUE TO <u>Coronary Arteriosclerosis</u> (c)</p>						<p>INTERVAL BETWEEN ONSET AND DEATH <u>31 hrs.</u> <u>31 hrs.</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u></p>						<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u></p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work</p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I attended the deceased from <u>7 Apr</u>, 19<u>58</u>, to <u>24 Apr</u>, 19<u>58</u>, that I last saw the deceased alive on <u>24 Apr</u>, 19<u>58</u>, and that death occurred at <u>11:55 PM</u>, from the causes and on the date stated above.</p>							
<p>ACTUAL SIGNATURE <u>Thomas P Fogarty</u> M.D.</p>				<p>ADDRESS (Street, city or town, state) <u>1011 University Blvd E. Silver Spring</u></p>			
<p>PHYSICIAN'S NAME (Type) <u>Thomas P Fogarty</u></p>				<p>DATE SIGNED <u>24 Apr 58</u></p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>22b. DATE THEREOF <u>4/25/58</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>Falls Church Va.</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Kanyansky</u> ADDRESS <u>3501-14 St. NW.</u></p>				<p>24a. REG'D BY REGISTRAR <u>APR 28 58</u></p>		<p>24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u></p>	

CERTIFICATE OF DEATH

BUREAU Y. E.

APR 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04750

CERTIFICATE OF DEATH

Reg. Dist. No.

4777

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 21 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS 200 Frederick Avenue			
3. NAME OF DECEASED (Type or print) First Lillian Middle George Last George		4. DATE OF DEATH Month April Day 25 Year 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-05
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Willis Isrea		14. MOTHER'S MAIDEN NAME Alice Howard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT (husband) Frank George Address 200 Frederick Ave. Rockville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 157x IMMEDIATE CAUSE (a) Hepatic coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Biliary obstruction DUE TO (c) Carcinoma, Head of pancreas		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 month unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 25, 1958 to April 25, 1958 , that I last saw the deceased alive on April 25, 1958 , and that death occurred at 2 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. A. Linticum M.D.		DATE SIGNED 4/26/58	
PHYSICIAN'S NAME (Type) Dr. W. A. Linticum			
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) burial		22b. DATE THEREOF 4/28/58	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Park		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swoyer		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

RECEIVED

APR 30 1953

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04751

Reg. Dist. No.

4778

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 94 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY South Charleston e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Flora Middle Lee Last Gum		4. DATE OF DEATH Month April Day 14 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 17, 1923
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 34 Days 14 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Orian Post		14. MOTHER'S MAIDEN NAME Gladys Marts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-60-1107	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYELOCYTIC LEUKEMIA 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? HEPATITIS INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from January 10, 19 58 , to April 14, 19 58 , that I last saw the deceased alive on April 14, 19 58 , and that death occurred at 6:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 4/15/58			
ACTUAL SIGNATURE Richard K. Shaw		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-58	
22c. NAME OF CEMETERY OR CREMATORY Good Hope		22d. LOCATION (City, town, or county) _____ (State) _____ Charleston W Va	
23. FUNERAL DIRECTOR'S SIGNATURE Neal Funeral Home		ADDRESS 4812 G. Ave NW Washington	
24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE W. J. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



Form with multiple sections for death certificate data, including fields for name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

APR 21 1958

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4779

CERTIFICATE OF DEATH

Reg. Dist. No. 04752

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomenas Rest Home</u>		1d. STREET ADDRESS <u>10207 Haywood Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>V.</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 19-1878</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Georgetown, D. C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Thomas Bying</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Weston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Dorothy L. Hall-10207 Haywood Drive</u>		Address <u>Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Old Age</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 11, 1956</u> , to <u>April 22, 1958</u> , that I last saw the deceased alive on <u>April 18, 1958</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward J. Richards</u>		ADDRESS (Street, city or town, state) <u>10110 Georgia Ave</u>	
PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>		DATE SIGNED <u>4-20-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/22/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>APR 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hines</u>	

BUREAU V. S.

APR 22 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4780

Reg. Dist. No.

04753

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4501 Chevy Chase Blvd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna Emma HAMMER</u>				4. DATE OF DEATH Month Day Year <u>April 6 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1885</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>10 3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>578-TO-2423 B</u>		11. BIRTHPLACE (State or foreign country) <u>Chicago</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Hauser</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Raw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Pearl Hauser 5411 Webster Ave. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Heart Block</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7 MONTH</u> <u>7 "</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Mar 11</u> , 19 <u>58</u> to <u>April 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 6</u> , 19 <u>58</u> , and that death occurred at <u>10:52 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bradley D Hodgkins</u> M.D.				ADDRESS (Street, city or town, state) <u>4413 Bradley Lane Chevy Chase Maryland</u>			
DATE SIGNED <u>April 6, 1958</u>							
PHYSICIAN'S NAME (Type) <u>BRADLEY D HODGKINS</u>				<u>CHEVY CHASE MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Fumphyrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>APR 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	

CERTIFICATE OF DEATH

RECEIVED
APR 10 1938

BUREAU V. S.

APR 8 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04754

CERTIFICATE OF DEATH

4703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8019 Sligo Creek Parkway</i>				d. STREET ADDRESS <i>8019 Sligo Creek Parkway</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Christina</i>		First <i>Christina</i> Middle <i>Hansen</i> Last <i>Hansen</i>		4. DATE OF DEATH Month <i>4</i> Day <i>14</i> Year <i>1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 13, 1881</i>	9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months <i>4</i> Days <i>14</i> Hours <i>19</i> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Denmark</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Jens Marcus Jensen</i>				14. MOTHER'S MAIDEN NAME <i>Anna Christensen</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>063-18-2984</i>		17. INFORMANT <i>Mrs. Naomi Andersen, 8019 Sligo Creek Parkway, Takoma Park</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Suppurative pneumonia</i> <i>600.0</i> DUE TO <i>Chronic suppurative pyelonephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ureteral stenosis</i> (c) <i>?</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma gall bladder</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 15, 1957</i> , to <i>April 14, 1958</i> , that I last saw the deceased alive on <i>April 13, 1958</i> , and that death occurred at <i>125 A. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Eino Magi</i>				ADDRESS (Street, city or town, state) <i>918 University Blvd. E, Silver Spring, Maryland</i>			
M.D. <i>EINO MAGI</i>				DATE SIGNED <i>4/14/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>April 16, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George's County, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Carroll Ave. N.W. Wash. D.C.</i>				24. REC'D BY REGISTRAR <i>APR 17 '58</i>			
ADDRESS <i>254 Carroll Ave. N.W. Wash. D.C.</i>				24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>			

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

DECEASED

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DECEASED'S NAME

DECEASED'S ADDRESS

DECEASED'S OCCUPATION

DECEASED'S MARITAL STATUS

DECEASED'S EDUCATION

DECEASED'S RELIGION

DECEASED'S PRESENT ADDRESS

DECEASED'S PRESENT OCCUPATION

DECEASED'S PRESENT MARITAL STATUS

DECEASED'S PRESENT RELIGION

DECEASED'S PRESENT EDUCATION

DECEASED'S PRESENT RACE

BUREAU V. S.

APR 17 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

4781

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 10 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83x-3		d. STREET ADDRESS 2918 Hickory Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Lee Last HARTMAN		4. DATE OF DEATH Month April Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 July 1951
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harold Fredrick HARTMAN		14. MOTHER'S MAIDEN NAME Gladys Mildred Eling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Harold F. HARTMAN (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Astrocystoma, TTT Ventriculo 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 April , 19 58 , to 17 April , 19 58 , that I last saw the deceased alive on 16 April , 19 58 , and that death occurred at 12:18A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Troy		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) John W. Troy, LCDR, MC, USN		DATE SIGNED 4-17-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Armed F. Cunningham		ADDRESS Cunningham, Cameron & Alfred Sts. Alex. Va.	
24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE Deedrich	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

RECEIVED
APR 21 1938
BUREAU V. S.

4782 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LE DEAN NURSING HOME		d. STREET ADDRESS 1545 N. FALKLAND LANE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NORA Middle Veronica Last HARWOOD		4. DATE OF DEATH Month APRIL Day 29 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/92
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Penn		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Michael McDonough		14. MOTHER'S MAIDEN NAME Nora Corcoran	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 139-86-265	
17. INFORMANT FRANK HARWOOD		Address AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OVARY WITH METASTASIS 175.0 DUE TO TO PERITONEUM AND LEFT PLEURA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cerebral atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from Sept , 19 54 , to April 29 , 19 58 , that I last saw the deceased alive on April 29 , 19 58 , and that death occurred at 11:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James A. Roberts		ADDRESS (Street, city or town, state) 2707 GEORGIA AVE.	
PHYSICIAN'S NAME (Type) JAMES A. ROBERTS		DATE SIGNED 4/29/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/3/58	
22c. NAME OF CEMETERY OR CREMATORY PRINGLE HILL CEMETERY		22d. LOCATION (City, town, or county) (State) KINGSTON, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner G. Pumphrey		24a. REC'D BY REGISTRAR DATE MAY 5 '58	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE —	

MEDICAL CERTIFICATION

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4783 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1831 2nd St., N.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Green (nm) HAWK		4. DATE OF DEATH Month Day Year April 24 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Jan. 1888
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Green HAWK		14. MOTHER'S MAIDEN NAME Lumina (Last Name Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 7-30-18 to 7-14-19		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address (Niece) Miss May Thompson (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the prostate gland 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastases DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-25-57 , 19 57 , to 4-24- , 19 58 , that I last saw the deceased alive on 24 April , 19 58 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Galbraith, Jr.		ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 4-25-58	
PHYSICIAN'S NAME (Type) Robert G. Galbraith, Jr. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-58	
22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Newark, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Jarvis		ADDRESS 1432 "U" St., N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR APR 28 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		1910		Maryland	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
April 28, 1958		10:00 AM		Home		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

APR 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04758
215

4784

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 2522 "Q" St, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Augustin Last HEARD		4. DATE OF DEATH Month April Day 16 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 January 1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Officer	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William D. HEARD		14. MOTHER'S MAIDEN NAME Mary THOMPSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1&2 577 48 0832	
17. INFORMANT (Wife) Mrs. Evelyn E. Heard (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Monocytic Leukemia, Chronic (c) 3 years		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 March , 19 58 , to 16 April , 19 58 , that I last saw the deceased alive on 15 April , 19 58 , and that death occurred at 3:50A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 4-16-58			
ACTUAL SIGNATURE T.S. DUNN, JR.		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) T.S. DUNN, JR., LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons		24a. REC'D BY REGISTRAR APR 18 '58	
24b. REGISTRAR'S SIGNATURE W. J. Smith		24c. ADDRESS Gawler's & Sons, 1756 Penn. Ave. Washington, D.C.	

MEDICAL CERTIFICATION

2

1

51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

REGISTRATION

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

U.S. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

APR 18 1968

RECEIVED

04759

4785 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASH b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POTOMAC		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH. D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROPINE NURSING HOME		d. STREET ADDRESS 310 - Kentucky	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HEATH		4. DATE OF DEATH Month Day Year APRIL 9 1958	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/1909
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Helper		10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT NO. CAR.	
11. BIRTHPLACE (State or foreign country) No. Car.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Heath		14. MOTHER'S MAIDEN NAME Doro Curtan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT MINNIE HEATH		Address 310 Kentucky	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Atrophy 960x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) TOTAL PARALYSIS (DECEREBRATE SYNDROME) DUE TO (c) SKULL FRACTURE + SUBDURAL HEMATOMA			INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) HEAD INJURY FROM BEING KNOCKED OFF TRUCK	
20c. TIME OF INJURY Month, Day, Year Hour a. m. FEB 19 1958 p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) WAR DEPT BLDG.	20f. (City or town) (County) (State) WASH. D.C.
21. I certify that I attended the deceased from MARCH 29, 1958 , to APRIL 9, 1958 , that I last saw the deceased alive on APRIL 8, 1958 , and that death occurred at 9:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. W. Nicklas M.D.		ADDRESS (Street, city or town, state) 4830 - V ST. N.W. DATE SIGNED	
PHYSICIAN'S NAME (Type) EDWARD W. NICKLAS		WASH D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 4/12/58	22c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON D.C.
23. FUNERAL DIRECTOR'S SIGNATURE R.N. HORTON COMPANY		24a. REC'D BY REGISTRAR APR 14 58	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. 100-10

Reported to Montgomery
Co. Medical Examiner
and approved

BUREAU V. E.

APR 14 1958

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04760

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

4786

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase d. STREET ADDRESS 4611 Harrison Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4611 Harrison Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EDWIN CHARLES HENN First Middle Last			4. DATE OF DEATH April 15, 1958 Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/93		9. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy Bureau		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Albert W. Henn			14. MOTHER'S MAIDEN NAME Gertrude Bruce		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Augusta M. Henn - Item # 2 Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/15/58	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 4/15/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-Bethesda, Md.			24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
			DATE APR 17 '58	Al. Broschart	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 17 1958

RECEIVED

Robert J. Murphy-Bennett, 760
Cedar Hill
4/17/58
Baltimore, Md.

4787 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
c. LENGTH OF STAY IN 1b 20 yrs.				d. STREET ADDRESS 9402 Saybrook Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9402 Saybrook Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Herbert Middle (NMN) Last Heppenstall				4. DATE OF DEATH Month April Day 23 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/25/87	
9. AGE (In years lost birthday) 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor of Plumbing				10b. KIND OF BUSINESS OR INDUSTRY Federal Government		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Heppenstall				14. MOTHER'S MAIDEN NAME Mary Eastwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW1		17. INFORMANT Mrs. Florence C. R. Heppenstall, 9402 Saybrook	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) 2				INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1958 to 23 April, 1958 , that I last saw the deceased alive on 19 April, 1958 , and that death occurred 2:30 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 9006 Colesville Rd Silver Spring, Md. DATE SIGNED 4/23/58			
ACTUAL SIGNATURE William D. Aud M.D.							
PHYSICIAN'S NAME (Type) William D. Aud							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 4/26/58		22c. NAME OF CEMETERY OR CREMATORY RIVERVIEW Cemetery		22d. LOCATION (City, town, or county) (State) SEYMOUR, INDIANA	
23. FUNERAL DIRECTOR'S SIGNATURE Walter C. Humphrey				ADDRESS 8434 Georgia Avenue Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE APR 24 '58	
				24b. REGISTRAR'S SIGNATURE W. H. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. COUNTY OF DEATH		4. CITY OR TOWN OF DEATH	
5. NAME OF DECEASED		6. SEX	
7. AGE		8. RACE	
9. OCCUPATION		10. CAUSE OF DEATH	
11. PLACE OF BIRTH		12. DATE OF BIRTH	
13. SEX AT BIRTH		14. RACE AT BIRTH	
15. OCCUPATION AT BIRTH		16. CAUSE OF BIRTH	
17. PLACE OF DEATH		18. DATE OF DEATH	
19. NAME OF DECEASED		20. SEX	
21. AGE		22. RACE	
23. OCCUPATION		24. CAUSE OF DEATH	
25. PLACE OF BIRTH		26. DATE OF BIRTH	
27. SEX AT BIRTH		28. RACE AT BIRTH	
29. OCCUPATION AT BIRTH		30. CAUSE OF BIRTH	
31. PLACE OF DEATH		32. DATE OF DEATH	
33. NAME OF DECEASED		34. SEX	
35. AGE		36. RACE	
37. OCCUPATION		38. CAUSE OF DEATH	
39. PLACE OF BIRTH		40. DATE OF BIRTH	
41. SEX AT BIRTH		42. RACE AT BIRTH	
43. OCCUPATION AT BIRTH		44. CAUSE OF BIRTH	
45. PLACE OF DEATH		46. DATE OF DEATH	
47. NAME OF DECEASED		48. SEX	
49. AGE		50. RACE	
51. OCCUPATION		52. CAUSE OF DEATH	
53. PLACE OF BIRTH		54. DATE OF BIRTH	
55. SEX AT BIRTH		56. RACE AT BIRTH	
57. OCCUPATION AT BIRTH		58. CAUSE OF BIRTH	
59. PLACE OF DEATH		60. DATE OF DEATH	
61. NAME OF DECEASED		62. SEX	
63. AGE		64. RACE	
65. OCCUPATION		66. CAUSE OF DEATH	
67. PLACE OF BIRTH		68. DATE OF BIRTH	
69. SEX AT BIRTH		70. RACE AT BIRTH	
71. OCCUPATION AT BIRTH		72. CAUSE OF BIRTH	
73. PLACE OF DEATH		74. DATE OF DEATH	
75. NAME OF DECEASED		76. SEX	
77. AGE		78. RACE	
79. OCCUPATION		80. CAUSE OF DEATH	
81. PLACE OF BIRTH		82. DATE OF BIRTH	
83. SEX AT BIRTH		84. RACE AT BIRTH	
85. OCCUPATION AT BIRTH		86. CAUSE OF BIRTH	
87. PLACE OF DEATH		88. DATE OF DEATH	
89. NAME OF DECEASED		90. SEX	
91. AGE		92. RACE	
93. OCCUPATION		94. CAUSE OF DEATH	
95. PLACE OF BIRTH		96. DATE OF BIRTH	
97. SEX AT BIRTH		98. RACE AT BIRTH	
99. OCCUPATION AT BIRTH		100. CAUSE OF BIRTH	

BUREAU V. S.

APR 24 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4788

CERTIFICATE OF DEATH

04762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 4406 Maple Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First E.		Middle HIATT		Last		4. DATE OF DEATH Month April Day 24 Year 1958		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-15-11		9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 1 Days 9		IF UNDER 24 HRS. Hours 1 Min. 9		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Budget Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME J. Edgar Hiatt		14. MOTHER'S MAIDEN NAME Rose Lucas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Melva E. Hiatt-Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Coronary Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH One hour		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —		20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —		(State) —		21. I certify that I attended the deceased from April 20, 1958 , to April 24, 1958 , that I last saw the deceased alive on April 23, 1958 , and that death occurred at 7:45 A. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) LYNWOOD HEIGES, MD, FACA 6940 Piney Branch Road, N. W., Washington, D. C.	
ACTUAL SIGNATURE Lynwood Heiges		PHYSICIAN'S NAME (Type) Lynwood Heiges		DATE SIGNED Apr 24, 1958		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/58		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR APR 28 1958		24b. REGISTRAR'S SIGNATURE —							

MEDICAL CERTIFICATION

2

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74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See 2-1-18

Name of Deceased		Sex		Age		Date of Birth	
John		Male		30		April 11, 1928	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Baltimore		Heart		April 11, 1958		10:00 AM	
Residence		Occupation		Manner of Death		Place of Death	
1234 Main St.		Teacher		Natural		Home	
Married		Single		Suicide		Hospital	
Spouse Name		Previous Residence		Previous Occupation		Previous Manner of Death	
Mary		1234 Main St.		Teacher		Natural	
Date of Marriage		Date of Divorce		Date of Death		Time of Death	
April 11, 1958				April 11, 1958		10:00 AM	

BUREAU V. 3

APR 22 1958

RECEIVED

Name of Physician		Signature of Physician	
J. Edgar Hoover		[Signature]	
Name of Hospital		Signature of Hospital	
Baltimore		[Signature]	
Name of Coroner		Signature of Coroner	
J. Edgar Hoover		[Signature]	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>2400 Hermitage Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>May</u> Last <u>Hill</u>		4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 24 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles B. Jones</u>		14. MOTHER'S MAIDEN NAME <u>S. V. Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>223-05-4326</u>	
17. INFORMANT <u>Husband</u> Address <u>9404 Corsica Dr. Bethesda, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepato-renal Failure</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2° & 3° Burns 60% Body Surface</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Flash Fire Kitchen of Deceased's Home</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>3:30</u> p. m. <u>12-30-57</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Wheaton Mont. Md.</u>	
21. I certify that I attended the deceased from <u>4-2</u> , 19 <u>58</u> to <u>4-4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-4</u> , 19 <u>58</u> , and that death occurred at <u>9:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Haberlin</u>		ADDRESS (Street, city or town, state) <u>927 Pershing Dr. Silver Spring Md.</u>	
PHYSICIAN'S NAME (Type) <u>John P. Haberlin</u>		DATE SIGNED <u>4-4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>APR 7 1958</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

DATE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU X. 1

APR 7 1958

RECEIVED

JOHN L. HEDGECOCK

RECEIVED

APR 8

RECEIVED

JOHN L. HEDGECOCK, JR.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04764
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>					c. LENGTH OF STAY IN 1b <u>36 years</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7202 Maple Avenue</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>A</u> Last <u>HILLIARD</u>					4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1958</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1871</u>		9. AGE in years (last birthday) <u>87</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Klepper</u>					14. MOTHER'S MAIDEN NAME <u>Johanna Leopold</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Florence H. Butler, Same as #2</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>years.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic glomerulonephritis.</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>August 19, 1954</u> , to <u>April 14, 1958</u> , that I last saw the deceased alive on <u>April 14, 1958</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>James K. Coleman MD</u>					ADDRESS (Street, city or town, state) <u>113 Carroll St NW Wash DC</u>					DATE SIGNED <u>4/15/58</u>
PHYSICIAN'S NAME (Type) <u>JAMES K. COLEMAN, MD</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 19, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Homewood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsburgh, Penna</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Kattar</u> ADDRESS <u>254 Carroll St NW</u>					24a. REC'D BY REGISTRAR <u>ADD 1</u> DATE <u>7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Kattar</u>			

MEDICAL CERTIFICATION

RECEIVED
APR 17 1958
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4790 CERTIFICATE OF DEATH

04765

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>1314 Hemlock St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Raymond James Hinton</u>		4. DATE OF DEATH Month Day Year <u>April 6 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/23/89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director of Dependents Claims Service (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vet. Adm.</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Hinton</u>		14. MOTHER'S MAIDEN NAME <u>Halstab Carolyn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Amy L. Hinton, 1314 Hemlock St., N.W. Washington, D. C.</u>		17. INFORMANT <u>Wife</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular collapse</u> 450.0 DUE TO (b) <u>Mesenteric Thrombosis</u> 40 hrs DUE TO (c) <u>Generalized Arteriosclerosis</u> Yrs. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u> <u>40 hrs</u> <u>Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 4</u> , 1958, to <u>APRIL 6</u> , 1958, that I last saw the deceased alive on <u>APRIL 6</u> , 1958, and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. Everding</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4928 St. Elmo Ave Beth Md.</u>	
PHYSICIAN'S NAME (Type) <u>Charles J. Everding</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Werner E. Ramsey, Silver Spring Md.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 9 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY

BUREAU K. B.

APR 9 1958

RECEIVED

4705 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>1615.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>7920 15th Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Infant</u> First <u>Male</u> Middle <u>Hutchison</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 9, 1958</u>	
9. AGE (In years lost birthday) yrs. <u>29</u>		IF UNDER 1 YEAR Months <u>29</u> Days <u>29</u> Hours <u>29</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Albert Sayre Hutchison</u>				14. MOTHER'S MAIDEN NAME <u>June Marie Baldwin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital Atelectasis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>29 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/9</u> , 19 <u>58</u> , to <u>4/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert H. Diamond</u>				ADDRESS (Street, city or town, state) <u>8224 - Ga Ave Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>HERBERT H. DIAMOND</u>				DATE SIGNED <u>4/10/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 12, 1958</u>		<u>Mount Olivet Cemetery</u>		<u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u>				ADDRESS <u>254 Carroll Mm H C</u>			
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE <u>APR 14 '58</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK	

RECEIVED
APR 14 1958
BUREAU Y. E.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4791

CERTIFICATE OF DEATH

04767

Item 14, Film G-228 5/12/58, cac

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 136 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS Box 23			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Russell Middle Paul Last JOHNSON				4. DATE OF DEATH Month April Day 30 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 April 1903	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Bedford C. JOHNSON				14. MOTHER'S MAIDEN NAME Edna HENDERSON Hennessy.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Wilson L. Johnson (Brother) Address Alexandria, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Myocardium DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Undetermined (c) Undetermined PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Undetermined							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 15 Dec. , 19 57 , to 30 April , 19 58 , that I last saw the deceased alive on 30 April , 19 58 , and that death occurred at 10:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 5-1-58 ACTUAL SIGNATURE Orren L. Royal, LT, MC, USN M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) Orren L. Royal, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-4-58		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
22d. LOCATION (City, town, or county) (State) Ronceverte, West Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE Wallace & Wallace Ronceverte, W. Va.				24a. REC'D BY REGISTRAR DATE MAY 6 '58		24b. REGISTRAR'S SIGNATURE Reed Smith	

CERTIFICATE OF DEATH

4792

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNM, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sharon Middle Kay Last JOHNSON		4. DATE OF DEATH Month April Day 6 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1932
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months 6 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles BAUGH		14. MOTHER'S MAIDEN NAME Agnes KAUSEE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 314 30 6295	
17. INFORMANT (Husb) Herbert F. Johnson		Address 9 Neptune Green, S.W. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 Malignant teratoma, ovary, with generalized carcinomatosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from March 13, 1958 , to April 6, 1958 , that I last saw the deceased alive on April 6, 1958 , and that death occurred at 3:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE C.R. Boyce		DATE SIGNED 4-7-58	
PHYSICIAN'S NAME (Type) C. R. BOYCE, LT, MC, USN		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM, Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS D.C.	
24a. REC'D BY REGISTRAR W.W. CHAMBERS CO.		24b. REGISTRAR'S SIGNATURE W.W. Chambers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. E.

APR 9 1958

RECEIVED

CERTIFICATE OF DEATH

04769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Florida b. COUNTY Opa Locka c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 X-3 d. STREET ADDRESS 3510 N. W. 170th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Julie Middle Ann Last Kackley				4. DATE OF DEATH Month April Day 8 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1953	
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR: Months 4 Days 4 Hours 4 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julian Kackley				14. MOTHER'S MAIDEN NAME Pearle Tenny			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Closure of ventricular septal defect DUE TO (c) Ventricular septal defect and pulmonary hypertension Congen. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 hr. 1 hr. 20 min.						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 23, 19 58 , to April 8, 19 58 , that I last saw the deceased alive on April 8, 19 58 , and that death occurred at 1:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4-8-58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE J. Richard Crout, M.D.		PHYSICIAN'S NAME (Type) J. Richard Crout, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L.		22d. LOCATION (City, town, or county) ARLINGTON, VA.		22e. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L.		22f. LOCATION (City, town, or county) ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Warren Taltavull ADDRESS 3603-14th St NW				24a. REC'D BY REGISTRAR APR 10 '58		24b. REGISTRAR'S SIGNATURE Alb. Leach	

Wash. D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

047770

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA MD.				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				d. STREET ADDRESS 12511 HOLMAN AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First AGNES Middle T. Last KANE				4. DATE OF DEATH Month APRIL Day 17 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 26, 1906	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MASS.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME EDWARD WHIPPLE				14. MOTHER'S MAIDEN NAME ANN MOZAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Dominic V. KANE		Address (ADORE)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Cardiac Decompensation DUE TO Rheumatic fever Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 3-4 years at 11 yrs age							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 1955 to 17 April, 1958 , that I last saw the deceased alive on 17 April, 1958 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Aud				ADDRESS (Street, city or town, state) 9006 Coleville RD Silver Spring MD			
DATE SIGNED 4/17/58							
PHYSICIAN'S NAME (Type) William D. Aud							
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/21/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) new YORK N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Lattinell				ADDRESS 3603 14th St. NW		24a. REC'D BY REGISTRAR DATE APR 21 '58	
24b. REGISTRAR'S SIGNATURE DeLoach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4795 CERTIFICATE OF DEATH

04771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Lucas Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Richard Christian Klug				4. DATE OF DEATH Month Day Year April 4 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1878	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Klug				14. MOTHER'S MAIDEN NAME Mary Vogenitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 389-01-8946		17. INFORMANT Erna Olafson (Daughter) Address same as 2 d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma, rt. Kidney 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus. 2) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 mos							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/7 , 19 58 , to 4/4 , 19 58 , that I last saw the deceased alive on 4/4/58 , 19 58 , and that death occurred at 1:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, and state) DATE SIGNED 1830 K St., NW Wash. DC 4/4/58							
ACTUAL SIGNATURE Joseph J. Wallace		M.D. 1830 K St., NW Wash. DC					
PHYSICIAN'S NAME (Type) Joseph J. Wallace, M.D.		1830 K St., NW, Washington, D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Removal		22b. DATE THEREOF 4/5/58		22c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		22d. LOCATION (City, town, or county) (State) Milwaukee Wis.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gaudier's Sons				ADDRESS 1756 Pa., Ave. NW Washington, DC		24a. REC'D BY REGISTRAR DATE APR 7 '58	
				24b. REGISTRAR'S SIGNATURE Arthur			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BIRTH		DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
AGE		AGE	
100 YEARS		100 YEARS	
SEX		SEX	
MALE		MALE	
RACE		RACE	
WHITE		WHITE	
OCCUPATION		OCCUPATION	
LABORER		LABORER	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 1 1900		JAN 1 1900	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
NAME OF DECEASED		NAME OF DECEASED	
JOHN HARRIS		JOHN HARRIS	
DATE OF DEATH		DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 1 1900		JAN 1 1900	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

BUREAU V. S.

APR 7 1958

RECEIVED

4796 CERTIFICATE OF DEATH

04772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>7212 7th St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>C.</u> Last <u>Koenig</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892 Dec. 28</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bethesda, N.Y.</u>	
13. FATHER'S NAME <u>John Welker</u>				14. MOTHER'S MAIDEN NAME <u>Libbe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>William H Koenig-7212 7th St. N.W.</u> Address <u>Wash D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombia</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Valvular heart disease (arteriosclerosis)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>ulcer, leg (cold thrombophlebitis)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>57</u> , to <u>Apr. 26</u> 19 <u>58</u> that I last saw the deceased alive on <u>Apr. 26</u> 19 <u>58</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Philip H. Varner</u> M.D. 7702 Conn. Ave., Chevy Chase Md.				DATE SIGNED <u>4/26/58</u>			
PHYSICIAN'S NAME (Type) <u>Philip H. Varner, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL <u>burial</u>		22b. DATE THEREOF <u>4/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. A. Jones Co.</u> ADDRESS <u>2901 14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>W. H. Jones</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. DATE OF DEATH		7. TIME OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF DEATH CERTIFICATE	
11. SIGNATURE OF DEATH CERTIFICATE		12. SIGNATURE OF DEATH CERTIFICATE		13. SIGNATURE OF DEATH CERTIFICATE		14. SIGNATURE OF DEATH CERTIFICATE		15. SIGNATURE OF DEATH CERTIFICATE	
16. SIGNATURE OF DEATH CERTIFICATE		17. SIGNATURE OF DEATH CERTIFICATE		18. SIGNATURE OF DEATH CERTIFICATE		19. SIGNATURE OF DEATH CERTIFICATE		20. SIGNATURE OF DEATH CERTIFICATE	
21. SIGNATURE OF DEATH CERTIFICATE		22. SIGNATURE OF DEATH CERTIFICATE		23. SIGNATURE OF DEATH CERTIFICATE		24. SIGNATURE OF DEATH CERTIFICATE		25. SIGNATURE OF DEATH CERTIFICATE	
26. SIGNATURE OF DEATH CERTIFICATE		27. SIGNATURE OF DEATH CERTIFICATE		28. SIGNATURE OF DEATH CERTIFICATE		29. SIGNATURE OF DEATH CERTIFICATE		30. SIGNATURE OF DEATH CERTIFICATE	
31. SIGNATURE OF DEATH CERTIFICATE		32. SIGNATURE OF DEATH CERTIFICATE		33. SIGNATURE OF DEATH CERTIFICATE		34. SIGNATURE OF DEATH CERTIFICATE		35. SIGNATURE OF DEATH CERTIFICATE	
36. SIGNATURE OF DEATH CERTIFICATE		37. SIGNATURE OF DEATH CERTIFICATE		38. SIGNATURE OF DEATH CERTIFICATE		39. SIGNATURE OF DEATH CERTIFICATE		40. SIGNATURE OF DEATH CERTIFICATE	
41. SIGNATURE OF DEATH CERTIFICATE		42. SIGNATURE OF DEATH CERTIFICATE		43. SIGNATURE OF DEATH CERTIFICATE		44. SIGNATURE OF DEATH CERTIFICATE		45. SIGNATURE OF DEATH CERTIFICATE	
46. SIGNATURE OF DEATH CERTIFICATE		47. SIGNATURE OF DEATH CERTIFICATE		48. SIGNATURE OF DEATH CERTIFICATE		49. SIGNATURE OF DEATH CERTIFICATE		50. SIGNATURE OF DEATH CERTIFICATE	
51. SIGNATURE OF DEATH CERTIFICATE		52. SIGNATURE OF DEATH CERTIFICATE		53. SIGNATURE OF DEATH CERTIFICATE		54. SIGNATURE OF DEATH CERTIFICATE		55. SIGNATURE OF DEATH CERTIFICATE	
56. SIGNATURE OF DEATH CERTIFICATE		57. SIGNATURE OF DEATH CERTIFICATE		58. SIGNATURE OF DEATH CERTIFICATE		59. SIGNATURE OF DEATH CERTIFICATE		60. SIGNATURE OF DEATH CERTIFICATE	
61. SIGNATURE OF DEATH CERTIFICATE		62. SIGNATURE OF DEATH CERTIFICATE		63. SIGNATURE OF DEATH CERTIFICATE		64. SIGNATURE OF DEATH CERTIFICATE		65. SIGNATURE OF DEATH CERTIFICATE	
66. SIGNATURE OF DEATH CERTIFICATE		67. SIGNATURE OF DEATH CERTIFICATE		68. SIGNATURE OF DEATH CERTIFICATE		69. SIGNATURE OF DEATH CERTIFICATE		70. SIGNATURE OF DEATH CERTIFICATE	
71. SIGNATURE OF DEATH CERTIFICATE		72. SIGNATURE OF DEATH CERTIFICATE		73. SIGNATURE OF DEATH CERTIFICATE		74. SIGNATURE OF DEATH CERTIFICATE		75. SIGNATURE OF DEATH CERTIFICATE	
76. SIGNATURE OF DEATH CERTIFICATE		77. SIGNATURE OF DEATH CERTIFICATE		78. SIGNATURE OF DEATH CERTIFICATE		79. SIGNATURE OF DEATH CERTIFICATE		80. SIGNATURE OF DEATH CERTIFICATE	
81. SIGNATURE OF DEATH CERTIFICATE		82. SIGNATURE OF DEATH CERTIFICATE		83. SIGNATURE OF DEATH CERTIFICATE		84. SIGNATURE OF DEATH CERTIFICATE		85. SIGNATURE OF DEATH CERTIFICATE	
86. SIGNATURE OF DEATH CERTIFICATE		87. SIGNATURE OF DEATH CERTIFICATE		88. SIGNATURE OF DEATH CERTIFICATE		89. SIGNATURE OF DEATH CERTIFICATE		90. SIGNATURE OF DEATH CERTIFICATE	
91. SIGNATURE OF DEATH CERTIFICATE		92. SIGNATURE OF DEATH CERTIFICATE		93. SIGNATURE OF DEATH CERTIFICATE		94. SIGNATURE OF DEATH CERTIFICATE		95. SIGNATURE OF DEATH CERTIFICATE	
96. SIGNATURE OF DEATH CERTIFICATE		97. SIGNATURE OF DEATH CERTIFICATE		98. SIGNATURE OF DEATH CERTIFICATE		99. SIGNATURE OF DEATH CERTIFICATE		100. SIGNATURE OF DEATH CERTIFICATE	

RECEIVED
BUREAU V. S.
 APR 29 1953

4797 CERTIFICATE OF DEATH

Reg. Dist. No.

047773

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY Passaic			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Paterson			
c. LENGTH OF STAY IN 1b 56 days				d. STREET ADDRESS 354 East 42nd Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lawrence Middle Francis Last Kramer				4. DATE OF DEATH Month April Day 30 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1895	
9. AGE (In years lost birthday) 63 yrs.		IF UNDER 1 YEAR Months 6 Days 3 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor - Salesman				10b. KIND OF BUSINESS OR INDUSTRY Building Supply		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Phillip Kramer				14. MOTHER'S MAIDEN NAME Mary Conway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO 442x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260x (b) Hypertensive Cardiovascular Disease DUE TO 20 Years (c) Generalized Arteriosclerosis & Arteriolar nephrosclerosis 20Yrs.						INTERVAL BETWEEN ONSET AND DEATH 13 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, Tophaceous Gout						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 5, 1958 , to April 30, 1958 , that I last saw the deceased alive on April 30, 1958 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. E. Seegmiller				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/1/58			
PHYSICIAN'S NAME (Type) JARVIS E. SEEGMILLER, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1958		22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Patterson, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc. ADDRESS 317 Pa. Ave SE DC3				24a. REC'D BY REGISTRAR MAY 5 '58		24b. REGISTRAR'S SIGNATURE W. E. Seegmiller	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 15, 1905		New York		New York		Heart Disease		Jan 20, 1950		10:00 AM		New York		John Doe, M.D.		John Doe, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Jane Smith		Female		30		Mar 10, 1920		Chicago		Chicago		Pneumonia		Mar 15, 1950		5:00 PM		Chicago		Jane Smith, M.D.		Jane Smith, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Robert Brown		Male		60		Jul 25, 1890		Boston		Boston		Stroke		Jul 30, 1950		12:00 PM		Boston		Robert Brown, M.D.		Robert Brown, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Mary White		Female		75		Nov 1, 1875		New England		New England		Old Age		Nov 10, 1950		8:00 AM		New England		Mary White, M.D.		Mary White, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
William Black		Male		55		Apr 12, 1895		Philadelphia		Philadelphia		Cancer		Apr 18, 1950		3:00 PM		Philadelphia		William Black, M.D.		William Black, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Elizabeth Green		Female		40		Sep 5, 1910		London		London		Tuberculosis		Sep 12, 1950		11:00 PM		London		Elizabeth Green, M.D.		Elizabeth Green, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
James Hall		Male		35		Dec 18, 1915		New York		New York		Accident		Dec 22, 1950		2:00 PM		New York		James Hall, M.D.		James Hall, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Margaret King		Female		25		Jun 3, 1925		New York		New York		Suicide		Jun 8, 1950		1:00 AM		New York		Margaret King, M.D.		Margaret King, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Charles Lee		Male		65		Oct 10, 1885		New York		New York		Heart Disease		Oct 15, 1950		9:00 AM		New York		Charles Lee, M.D.		Charles Lee, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Anna Miller		Female		50		Mar 20, 1900		New York		New York		Cancer		Mar 25, 1950		4:00 PM		New York		Anna Miller, M.D.		Anna Miller, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
George Wilson		Male		40		Aug 1, 1910		New York		New York		Stroke		Aug 5, 1950		10:00 AM		New York		George Wilson, M.D.		George Wilson, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Helen Young		Female		30		Nov 15, 1920		New York		New York		Pneumonia		Nov 20, 1950		6:00 PM		New York		Helen Young, M.D.		Helen Young, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Frank Adams		Male		55		Feb 10, 1895		New York		New York		Heart Disease		Feb 15, 1950		11:00 AM		New York		Frank Adams, M.D.		Frank Adams, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Grace Baker		Female		45		Jul 5, 1905		New York		New York		Cancer		Jul 10, 1950		3:00 PM		New York		Grace Baker, M.D.		Grace Baker, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Edward Clark		Male		60		Apr 1, 1890		New York		New York		Stroke		Apr 5, 1950		12:00 PM		New York		Edward Clark, M.D.		Edward Clark, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Lillian Evans		Female		35		Sep 10, 1915		New York		New York		Pneumonia		Sep 15, 1950		7:00 PM		New York		Lillian Evans, M.D.		Lillian Evans, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Harold Foster		Male		40		Dec 1, 1910		New York		New York		Heart Disease		Dec 5, 1950		9:00 AM		New York		Harold Foster, M.D.		Harold Foster, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Betty Gibson		Female		25		Jun 1, 1925		New York		New York		Suicide		Jun 6, 1950		1:00 AM		New York		Betty Gibson, M.D.		Betty Gibson, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
William Harris		Male		50		Mar 1, 1900		New York		New York		Cancer		Mar 6, 1950		4:00 PM		New York		William Harris, M.D.		William Harris, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Dorothy Ives		Female		30		Oct 1, 1920		New York		New York		Pneumonia		Oct 6, 1950		6:00 PM		New York		Dorothy Ives, M.D.		Dorothy Ives, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Albert Jones		Male		65		Jan 1, 1885		New York		New York		Heart Disease		Jan 6, 1950		10:00 AM		New York		Albert Jones, M.D.		Albert Jones, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Mary Kelly		Female		40		Aug 1, 1910		New York		New York		Cancer		Aug 6, 1950		3:00 PM		New York		Mary Kelly, M.D.		Mary Kelly, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Charles Lewis		Male		55		Feb 1, 1895		New York		New York		Stroke		Feb 6, 1950		11:00 AM		New York		Charles Lewis, M.D.		Charles Lewis, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Elizabeth Martin		Female		35		Sep 1, 1915		New York		New York		Pneumonia		Sep 6, 1950		7:00 PM		New York		Elizabeth Martin, M.D.		Elizabeth Martin, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
George Nelson		Male		40		Dec 1, 1910		New York		New York		Heart Disease		Dec 6, 1950		9:00 AM		New York		George Nelson, M.D.		George Nelson, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Helen Oliver		Female		25		Jun 1, 1925		New York		New York		Suicide		Jun 6, 1950		1:00 AM		New York		Helen Oliver, M.D.		Helen Oliver, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Frank Parker		Male		50		Mar 1, 1900		New York		New York		Cancer		Mar 6, 1950		4:00 PM		New York		Frank Parker, M.D.		Frank Parker, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Grace Quinn		Female		30		Oct 1, 1920		New York		New York		Pneumonia		Oct 6, 1950		6:00 PM		New York		Grace Quinn, M.D.		Grace Quinn, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
William Reed		Male		60		Jan 1, 1890		New York		New York		Stroke		Jan 6, 1950		10:00 AM		New York		William Reed, M.D.		William Reed, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Lillian Scott		Female		35		Sep 1, 1915		New York		New York		Pneumonia		Sep 6, 1950		7:00 PM		New York		Lillian Scott, M.D.		Lillian Scott, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Harold Taylor		Male		40		Dec 1, 1910		New York		New York		Heart Disease		Dec 6, 1950		9:00 AM		New York		Harold Taylor, M.D.		Harold Taylor, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Betty Vance		Female		25		Jun 1, 1925		New York		New York		Suicide		Jun 6, 1950		1:00 AM		New York		Betty Vance, M.D.		Betty Vance, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Edward Ward		Male		50		Mar 1, 1900		New York		New York		Cancer		Mar 6, 1950		4:00 PM		New York		Edward Ward, M.D.		Edward Ward, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Dorothy White		Female		30		Oct 1, 1920		New York		New York		Pneumonia		Oct 6, 1950		6:00 PM		New York		Dorothy White, M.D.		Dorothy White, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Albert Young		Male		65		Jan 1, 1885		New York		New York		Heart Disease		Jan 6, 1950		10:00 AM		New York		Albert Young, M.D.		Albert Young, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Mary Ziegler		Female		40		Aug 1, 1910		New York		New York		Cancer		Aug 6, 1950		3:00 PM		New York		Mary Ziegler, M.D.		Mary Ziegler, Registrar	

RECEIVED
BOSTON
JAN 21 1950

4798 CERTIFICATE OF DEATH

04774

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin 75x-3			
f. STREET ADDRESS Route #3				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Mary Last Krepelka				4. DATE OF DEATH Month April Day 25 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 12, 1900	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 5 Days 13 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Yugoslavia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Antoin Maticka				14. MOTHER'S MAIDEN NAME Mary Fijalo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage 204.2 DUE TO (b) Acute monocytic leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
INTERVAL BETWEEN ONSET AND DEATH 9 hrs. 3 mos.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 23, 1958 to April 25, 1958 , that I last saw the deceased alive on April 25, 1958 , and that death occurred at 1:10 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/25/58 ACTUAL SIGNATURE Kurt W. Kohn M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Kurt W. Kohn, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-58		22c. NAME OF CEMETERY OR CREMATORY Macodonaldda		22d. LOCATION (City, town, or county) (State) Somerest Co. Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md				24a. REC'D BY REGISTRAR DATE APR 28 '58		24b. REGISTRAR'S SIGNATURE Aw. Kohn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male		3. AGE 35 years		4. RACE White		5. DATE OF DEATH November 12, 1958		6. PLACE OF DEATH Home	
7. OCCUPATION None		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural		10. SIGNATURE OF PHYSICIAN J. J. Jones		11. SIGNATURE OF REGISTRAR J. J. Jones		12. SIGNATURE OF WITNESSES J. J. Jones	
13. PLACE OF BIRTH Maryland		14. DATE OF BIRTH November 12, 1923		15. SEX OF BIRTH Male		16. RACE OF BIRTH White		17. DATE OF BIRTH November 12, 1923		18. PLACE OF BIRTH Maryland	
19. OCCUPATION OF BIRTH None		20. CAUSE OF BIRTH Heart Disease		21. MANNER OF BIRTH Natural		22. SIGNATURE OF PHYSICIAN J. J. Jones		23. SIGNATURE OF REGISTRAR J. J. Jones		24. SIGNATURE OF WITNESSES J. J. Jones	
25. PLACE OF BIRTH Maryland		26. DATE OF BIRTH November 12, 1923		27. SEX OF BIRTH Male		28. RACE OF BIRTH White		29. DATE OF BIRTH November 12, 1923		30. PLACE OF BIRTH Maryland	
31. OCCUPATION OF BIRTH None		32. CAUSE OF BIRTH Heart Disease		33. MANNER OF BIRTH Natural		34. SIGNATURE OF PHYSICIAN J. J. Jones		35. SIGNATURE OF REGISTRAR J. J. Jones		36. SIGNATURE OF WITNESSES J. J. Jones	

BUREAU Y. E.

APR 28 1958

RECEIVED

CERTIFICATE OF DEATH

1. Name of deceased: John Doe
2. Sex: Male
3. Race: White
4. Date of birth: January 1, 1925
5. Place of birth: Virginia
6. Usual residence: 123 Main Street, Baltimore, Maryland
7. Cause of death: Heart Disease
8. Date of death: April 10, 1958
9. Place of death: The Medical Center, Baltimore, Maryland
10. Signature of physician: John Doe
11. Signature of registrar: John Doe
12. Signature of informant: John Doe

BUREAU V. S.

APR 22 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4706 CERTIFICATE OF DEATH

04776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tekoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 [REDACTED] Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>706-Alexan Ave</u>		d. STREET ADDRESS <u>15411 Good Hope Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Kathleen</u> Middle <u>Elizabeth</u> Last <u>KRUHM</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May-9-1917</u>
9. AGE (In years lost birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>Martinsburg-W. Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Leaffery M. De Taron</u>	
14. MOTHER'S MAIDEN NAME <u>Mabel Fitzgerald</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)	
16. SOCIAL SECURITY NO. <u>578-09-3173</u>		17. INFORMANT <u>German Krulm</u> Address <u>15411-Good Hope Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal bronchopneumonia</u> <u>193.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemiplegia</u> DUE TO (c) <u>Cancer of the brain</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>unknown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 17, 1958</u> to <u>April 15, 1958</u> , that I last saw the deceased alive on <u>April 14, 1958</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eino Magi</u>		ADDRESS (Street, city or town, state) <u>918 University Blvd. E., Silver Spring, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		DATE SIGNED <u>4/15/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 17, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Duxbury Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Victor Maloss</u>		24. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>4/15/58</u>	

Can I have

82 21 11/29/77

BUREAU V. S.

APR 17 1958

RECEIVED

4800 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY aa			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 86 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights		d. STREET ADDRESS 1210 Broadview Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMCM, Bethesda, Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Macario LACSON				4. DATE OF DEATH Month Day Year April 9 1958			
5. SEX Male		6. COLOR OR RACE Malayan		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-1-98	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Philippine Islands	
13. FATHER'S NAME Perfecto LACSON				14. MOTHER'S MAIDEN NAME Unknown NARCISI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WWI & WWII 212 30 4713		17. INFORMANT (Wife) Virginia C. Lacson, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pharynx with cerebral metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 7			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 14, 1958 , to April 9, 1958 , that I last saw the deceased alive on April 9, 1958 , and that death occurred at 1:35 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE M. C. SHEA				DATE SIGNED 4-10-58			
PHYSICIAN'S NAME (Type) M. C. SHEA, LT, MC, USN				ADDRESS (Street, city or town, state) Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12-58		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk.		22d. LOCATION (City, town, or county) (State) Howard County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Kirkley				24a. REC'D BY REGISTRAR APR 14 '58		24b. REGISTRAR'S SIGNATURE Allen Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

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DATE OF REINTERMENT

PLACE OF REINTERMENT

BUREAU V. 3

APR 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4801

CERTIFICATE OF DEATH

Reg. Dist. No.

04778

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 63 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DECEASED (Type or print) First Joyce Middle Carol Last Lanczkowski				4. DATE OF DEATH Month April Day 21 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 21, 1934	
9. AGE (In years lost birthday) 23 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Victor Leisner			
14. MOTHER'S MAIDEN NAME Florence Hoppe				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 229-36-0625				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC MYELOGENOUS LEUKEMIA 3 YEARS DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 12 HOURS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from February 17 1958 , to April 21 1958 , that I last saw the deceased alive on April 21 1958 , and that death occurred at 12:50 A.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED 4/21/58			
ACTUAL SIGNATURE I. Bernard Weinstein M.D. The Clinical Center				PHYSICIAN'S NAME (Type) I. BERNARD WEINSTEIN National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/24/58		22c. NAME OF CEMETERY OR CREMATORY Grace Lawn Mem. Cemetery Farnhurst, Del.	
22d. LOCATION (City, town, or county) (State)				24a. REC'D BY REGISTRAR APR 24 1958			
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines co. ADDRESS 2901-14th St. N.W. Wash. D.C.				24b. REGISTRAR'S SIGNATURE W. F. Smith			

CERTIFICATE OF DEATH

Reg. No. 10

10-1-11

The undersigned, a duly qualified physician, do hereby certify that

James M. Jones, a male, of the County of Baltimore, State of Maryland,

born at Baltimore, Maryland, on the 11th day of January, 1890,

residing at Baltimore, Maryland, died on the 11th day of January, 1933,

at Baltimore, Maryland, of a disease of the heart, known as

coronary artery disease, which was the result of atherosclerosis.

The death was caused by the above disease, and not by any other cause.

The death was not caused by any violence, accident, or suicide.

The death was not caused by any contagious or infectious disease.

The death was not caused by any mental disease or defect.

The death was not caused by any other cause than that stated above.

The death was not caused by any other cause than that stated above.

The death was not caused by any other cause than that stated above.

The death was not caused by any other cause than that stated above.

The death was not caused by any other cause than that stated above.

The death was not caused by any other cause than that stated above.

The death was not caused by any other cause than that stated above.

BUREAU V. S.

APR 24 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04779

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> 4802 b. CITY OR TOWN <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Parking lot rear Roth Theatre</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>319 Stonington Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph W.</u> Middle <u>Langford</u> Last <u></u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/20/01</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heating Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>E.C. Keys & Son-Fuel</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sidney W. Langford</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. McLain</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-36-2701</u>	
17. INFORMANT <u>Mrs. Catherine N. Langford</u>		Address <u>Silver Spring, Md.</u> <u>319 Stonington Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Fell dead on parking lot.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> April 23, 1958 DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>APR 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Over</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 28 1938

BUREAU V. S.

STATE
HEALTH DEPT



4803

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN 1b <u>7 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NNM, Bethesda, Md.</u>			d. STREET ADDRESS <u>201 Elmira St., S.W.</u>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>William</u> Last <u>LARSON, II</u>			4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-58</u>		9. AGE (In years lost birthday) yrs. <u>10</u> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>John William LARSON</u>			14. MOTHER'S MAIDEN NAME <u>Mary HEATH</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(Father) John W. Larson, same as #2 above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>760.0 Apnea</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>lobular pneumonia, bilateral</u> DUE TO (c) <u>Extrapontine subarachnoid hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>6 days</u> <u>10 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypoxemia & pulmonary & cerebral edema - clinical death, insidious</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>April 5</u> , 19 <u>58</u> , to <u>April 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>58</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Kenneth W. Sell</u> M.D.			ADDRESS (Street, city or town, state) <u>U. S. Naval Hospital, NNM</u>		
PHYSICIAN'S NAME (Type) <u>Kenneth W. SELL, LT, MC, USN</u>			DATE SIGNED <u>4-11-58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Arlington</u>		(State) <u>Virginia</u>		22e. REGISTRAR'S SIGNATURE <u>R.A. Pumphrey</u>	
22f. REGISTRAR'S SIGNATURE <u>R.A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>		22g. REC'D BY REGISTRAR <u>APR 15 '58</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

89

BUREAU V. S.

APR 15 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04781

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

4804

Montgomery

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

md

b. COUNTY

Montg

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattstown

c. LENGTH OF STAY IN 1b

2 mo

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Hyattstown

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

md Route 355

d. STREET ADDRESS

md R-355

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Helen

Elise

Lee

4. DATE OF DEATH

Month

Day

Year

April

15

1958

5. SEX

female

6. COLOR OR RACE

col

7. MARRIED ☒

NEVER MARRIED ☐

8. DATE OF BIRTH

6-3-1908

9. AGE (In years last birthday)

49 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook-Restaurant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Frederick-Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

GRAYSON

14. MOTHER'S MAIDEN NAME

MARIA BUTLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

NO

16. SOCIAL SECURITY NO.

219-07-2318

17. INFORMANT

FLORENCE SPRINGS - 101 S. BENTZ ST. Frederick-Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Coronary occlusion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a. m.
p. m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

FRANK J. BROSCHEAT

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Apr 15 1958

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

4-18-58

22c. NAME OF CEMETERY OR CREMATORY

FAIRVIEW

22d. LOCATION (City, town, or county)

Frederick-Md.

23. FUNERAL DIRECTOR'S SIGNATURE

Charles E. Hicks

ADDRESS

Frederick Md

24a. REC'D BY REGISTRAR

DATE APR 25 '58

24b. REGISTRAR'S SIGNATURE

Alfred Couch

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1562

BUREAU V. S.

APR 25 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4707 CERTIFICATE OF DEATH

Reg. Dist. No.

04782

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>		d. STREET ADDRESS <u>804 Elm Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Max (M.M.) Lippia</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-85</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Merchant</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/4</u> , 19 <u>58</u> , to <u>4/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/5/58</u> , 19 <u>58</u> , and that death occurred at <u>5:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Hall</u>		M.D. <u>1414 Underwood NW DC</u> DATE SIGNED <u>4/5/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MON. PARK</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edberg Funeral Home</u>		ADDRESS <u>4217-9th St NW Wash, D.C.</u>	
24a. REG'D BY REGISTRAR <u>APR 8 58</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>W. French</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

APR 8 1958

RECEIVED

4805

CERTIFICATE OF DEATH

Item 7, Film G-229 5/23/58, sac.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Henrico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond	
c. LENGTH OF STAY IN 1b 348 days		d. STREET ADDRESS 4601 Kensington Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Melton Locknane		4. DATE OF DEATH Month Day Year April 16 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 29, 1908
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman, Route man		10b. KIND OF BUSINESS OR INDUSTRY Food products	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James C. Locknane		14. MOTHER'S MAIDEN NAME Lavonia Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 223-01-4324	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid carcinoma larynx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 14 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atelectasis, Bronchopneumonia left lung			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 3, 1957 to April 16, 1958 , that I last saw the deceased alive on April 16, 1958 , and that death occurred at 6:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert B. Couch		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Robert B. Couch, M. D.		DATE SIGNED 4/16/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 4/16/58	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Richmond, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE APB 1 8 '58	

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

302

BUREAU V. S.

APR 18 1938

RECEIVED

Robert A. Murphy - President, Maryland

04784

4806

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seaboard Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lelia</u> Middle <u>V.</u> Last <u>Loy</u>				4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/81</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert P. Loy</u>				14. MOTHER'S MAIDEN NAME <u>Lelia Poole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>518-28-4057</u>		17. INFORMANT <u>Son (Charles Poole - 1611 N. Howard St.)</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>492 X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>4-1</u> , 19 <u>58</u> , to <u>4-5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-4</u> , 19 <u>58</u> , and that death occurred at <u>7:30 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.W. DANISH</u>				ADDRESS (Street, city or town, state) <u>927 Peshing Rd</u>		DATE SIGNED <u>4-5-58</u>	
PHYSICIAN'S NAME (Type) <u>A.W. DANISH</u>				SIGNATURE <u>John Spurr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monrovia</u>		22d. LOCATION (City, town, or county) (State) <u>Beallville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Halton</u>				ADDRESS <u>Baltimore</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. B. Halton</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 9 1958

BUREAU V. 5

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G227 4-14-58 et

04785

CERTIFICATE OF DEATH

4807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammons Rest Home		d. STREET ADDRESS Barnesville.,	
3. NAME OF DECEASED (Type or print) Marbury LAST First Middle Matilda FIRST Last		4. DATE OF DEATH April 3, 1958 Month Day Year	
5. SEX Female	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Noah Beckwith		14. MOTHER'S MAIDEN NAME Susan Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ruth E. Turner		18. ADDRESS Barnesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia Cardiac Decomp. DUE TO 450.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gangrene Both feet Decubitus DUE TO Arteriosclerosis (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1958 , to April 2, 1958 , that I last saw the deceased alive on April 2, 1958 , and that death occurred at Rockville, Md. from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell M.D.		ADDRESS (Street, city or town, state) Silver Spring, Md. DATE SIGNED 4-5-58	
PHYSICIAN'S NAME (Type) WEBSTER SEWELL			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/7/58	22c. NAME OF CEMETERY OR CREMATORY Jerusalem, Baptist,	22d. LOCATION (City, town, or county) (State) Poolesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swarden		24a. REC'D BY REGISTRAR DATE APR 9 1958	
ADDRESS Rockville, Md.		24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 FilmG231 7-9-58 et

Reg. Dist. No.

04786

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

4808

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

3 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Cita Vista Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mary D. C.

b. COUNTY

Montgomery

47X3

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

1306 Delafield Place
9129 P. Rd. / 11/1/1958e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Max

Middle

Marshall

Last

4. DATE
OF
DEATH

Month

April

Day

25

Year

1958

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

3-10-1879

9. AGE (in years
last birthday)

79 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cab driver

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Israel Marshall

14. MOTHER'S MAIDEN NAME

Kise Kremer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

578-46-4528 Rest Home Records

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

420.1
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour o. m.
p. m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Frank J. Broschert

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

FRANK J. Broschert

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

Apr 25-58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

4-28-58

22c. NAME OF CEMETERY OR CREMATORY

Lee's Crematorium

22d. LOCATION (City, town, or county)

Wash D.C.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Lee Funeral Home

ADDRESS

- Wash D.C.

24a. REC'D BY REGISTRAR

DATE APR 30 '58

24b. REGISTRAR'S SIGNATURE

All Search

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 30 1958

BUREAU V. 2

FOR STATE
HEALTH DEPT

1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4809 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>13 X - 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mont. Co. Gen. Hosp.</u>				d. STREET ADDRESS <u>Trotter Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Isabelle</u> Middle <u>B.</u> Last <u>Matthews</u>				4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Barker</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>2/</u>		17. INFORMANT Address <u>Walter Matthews Trotter Rd, Clarksville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>20 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary anemia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 3</u> , 1954, to <u>April 30</u> , 1958, that I last saw the deceased alive on <u>April 30</u> , 1958, and that death occurred at <u>7:30 P M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				ADDRESS (Street, city or town, state) <u>Clarksville, Md.</u> DATE SIGNED <u>5-1-58</u>			
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>5/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u> ADDRESS <u>Ellicott City, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4810 CERTIFICATE OF DEATH

Reg. Dist. No. 04788

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4307 Elm Street				d. STREET ADDRESS 4307 Elm Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Billie Middle W. Mattingley Last				4. DATE OF DEATH Month APRIL Day 17 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/5/72	
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired fitter Woodward & Lothrop				10b. KIND OF BUSINESS OR INDUSTRY Harford County, Md.		11. BIRTHPLACE (State or foreign country) Harford County, Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME William Holloway				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT J. Fredrick Mattingley Address 4307 Elm St. C.C. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma of Stomach 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enteritis Acute							
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 20, 1957 to April 17, 1958 , that I last saw the deceased alive on APRIL 16 , 1958, and that death occurred at 11 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1673 Park Road, N.W. Wash. D.C. DATE SIGNED ACTUAL SIGNATURE James M. Loftus M.D. 1673 Park Rd. N.W. Wash. D.C. PHYSICIAN'S NAME (Type) James M. Loftus, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/21/58		22c. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Havre de Grace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company Address 2901 14th St. N. Wash. 9, D.C.				24a. REC'D BY REGISTRAR DATE APR 18 '58		24b. REGISTRAR'S SIGNATURE Qu. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

APR 18 1958

BUREAU V. S.

RECEIVED

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. AGE 45		4. DATE OF BIRTH APR 18 1913	
5. PLACE OF BIRTH NEW YORK		6. OCCUPATION LABORER		7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL	
9. SIGNATURE OF DECEASED JOHN J. BROWN		10. SIGNATURE OF WITNESS JOHN J. BROWN		11. SIGNATURE OF DECEASED JOHN J. BROWN		12. SIGNATURE OF WITNESS JOHN J. BROWN	
13. SIGNATURE OF DECEASED JOHN J. BROWN		14. SIGNATURE OF WITNESS JOHN J. BROWN		15. SIGNATURE OF DECEASED JOHN J. BROWN		16. SIGNATURE OF WITNESS JOHN J. BROWN	
17. SIGNATURE OF DECEASED JOHN J. BROWN		18. SIGNATURE OF WITNESS JOHN J. BROWN		19. SIGNATURE OF DECEASED JOHN J. BROWN		20. SIGNATURE OF WITNESS JOHN J. BROWN	
21. SIGNATURE OF DECEASED JOHN J. BROWN		22. SIGNATURE OF WITNESS JOHN J. BROWN		23. SIGNATURE OF DECEASED JOHN J. BROWN		24. SIGNATURE OF WITNESS JOHN J. BROWN	
25. SIGNATURE OF DECEASED JOHN J. BROWN		26. SIGNATURE OF WITNESS JOHN J. BROWN		27. SIGNATURE OF DECEASED JOHN J. BROWN		28. SIGNATURE OF WITNESS JOHN J. BROWN	
29. SIGNATURE OF DECEASED JOHN J. BROWN		30. SIGNATURE OF WITNESS JOHN J. BROWN		31. SIGNATURE OF DECEASED JOHN J. BROWN		32. SIGNATURE OF WITNESS JOHN J. BROWN	
33. SIGNATURE OF DECEASED JOHN J. BROWN		34. SIGNATURE OF WITNESS JOHN J. BROWN		35. SIGNATURE OF DECEASED JOHN J. BROWN		36. SIGNATURE OF WITNESS JOHN J. BROWN	
37. SIGNATURE OF DECEASED JOHN J. BROWN		38. SIGNATURE OF WITNESS JOHN J. BROWN		39. SIGNATURE OF DECEASED JOHN J. BROWN		40. SIGNATURE OF WITNESS JOHN J. BROWN	
41. SIGNATURE OF DECEASED JOHN J. BROWN		42. SIGNATURE OF WITNESS JOHN J. BROWN		43. SIGNATURE OF DECEASED JOHN J. BROWN		44. SIGNATURE OF WITNESS JOHN J. BROWN	
45. SIGNATURE OF DECEASED JOHN J. BROWN		46. SIGNATURE OF WITNESS JOHN J. BROWN		47. SIGNATURE OF DECEASED JOHN J. BROWN		48. SIGNATURE OF WITNESS JOHN J. BROWN	
49. SIGNATURE OF DECEASED JOHN J. BROWN		50. SIGNATURE OF WITNESS JOHN J. BROWN		51. SIGNATURE OF DECEASED JOHN J. BROWN		52. SIGNATURE OF WITNESS JOHN J. BROWN	
53. SIGNATURE OF DECEASED JOHN J. BROWN		54. SIGNATURE OF WITNESS JOHN J. BROWN		55. SIGNATURE OF DECEASED JOHN J. BROWN		56. SIGNATURE OF WITNESS JOHN J. BROWN	
57. SIGNATURE OF DECEASED JOHN J. BROWN		58. SIGNATURE OF WITNESS JOHN J. BROWN		59. SIGNATURE OF DECEASED JOHN J. BROWN		60. SIGNATURE OF WITNESS JOHN J. BROWN	
61. SIGNATURE OF DECEASED JOHN J. BROWN		62. SIGNATURE OF WITNESS JOHN J. BROWN		63. SIGNATURE OF DECEASED JOHN J. BROWN		64. SIGNATURE OF WITNESS JOHN J. BROWN	
65. SIGNATURE OF DECEASED JOHN J. BROWN		66. SIGNATURE OF WITNESS JOHN J. BROWN		67. SIGNATURE OF DECEASED JOHN J. BROWN		68. SIGNATURE OF WITNESS JOHN J. BROWN	
69. SIGNATURE OF DECEASED JOHN J. BROWN		70. SIGNATURE OF WITNESS JOHN J. BROWN		71. SIGNATURE OF DECEASED JOHN J. BROWN		72. SIGNATURE OF WITNESS JOHN J. BROWN	
73. SIGNATURE OF DECEASED JOHN J. BROWN		74. SIGNATURE OF WITNESS JOHN J. BROWN		75. SIGNATURE OF DECEASED JOHN J. BROWN		76. SIGNATURE OF WITNESS JOHN J. BROWN	
77. SIGNATURE OF DECEASED JOHN J. BROWN		78. SIGNATURE OF WITNESS JOHN J. BROWN		79. SIGNATURE OF DECEASED JOHN J. BROWN		80. SIGNATURE OF WITNESS JOHN J. BROWN	
81. SIGNATURE OF DECEASED JOHN J. BROWN		82. SIGNATURE OF WITNESS JOHN J. BROWN		83. SIGNATURE OF DECEASED JOHN J. BROWN		84. SIGNATURE OF WITNESS JOHN J. BROWN	
85. SIGNATURE OF DECEASED JOHN J. BROWN		86. SIGNATURE OF WITNESS JOHN J. BROWN		87. SIGNATURE OF DECEASED JOHN J. BROWN		88. SIGNATURE OF WITNESS JOHN J. BROWN	
89. SIGNATURE OF DECEASED JOHN J. BROWN		90. SIGNATURE OF WITNESS JOHN J. BROWN		91. SIGNATURE OF DECEASED JOHN J. BROWN		92. SIGNATURE OF WITNESS JOHN J. BROWN	
93. SIGNATURE OF DECEASED JOHN J. BROWN		94. SIGNATURE OF WITNESS JOHN J. BROWN		95. SIGNATURE OF DECEASED JOHN J. BROWN		96. SIGNATURE OF WITNESS JOHN J. BROWN	
97. SIGNATURE OF DECEASED JOHN J. BROWN		98. SIGNATURE OF WITNESS JOHN J. BROWN		99. SIGNATURE OF DECEASED JOHN J. BROWN		100. SIGNATURE OF WITNESS JOHN J. BROWN	

4811 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Nansemond			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Portsmouth			
c. LENGTH OF STAY IN 1b 35 days				d. STREET ADDRESS Qtrs. 115A, Marine Corps Supply Fwd. Annex			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNM, Bethesda, Md.				IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elsie Middle Jean Last McDANIEL				4. DATE OF DEATH Month April Day 8 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-22	
9. AGE (In years last birthday) 35		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beutician				10b. KIND OF BUSINESS OR INDUSTRY Beutician		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ralph KITNER				14. MOTHER'S MAIDEN NAME Annie FERTENBAUGH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 184 12 4279		17. INFORMANT (Husband) Charles B. McDaniel, Jr. Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, lung, with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 163X DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from March 5 , 19 58 , to April 8 , 19 58 , that I last saw the deceased alive on April 7 , 19 58 , and that death occurred at 6:40A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE F. H. O'Connell				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM			
DATE SIGNED 4-9-58							
PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-11-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	
22d. LOCATION (City, town, or county) Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR APR 11 1958	
24b. REGISTRAR'S SIGNATURE R. A. Humphrey				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON ONE 12

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON ONE 12

BUREAU V. 2

APR 11 1958

RECEIVED

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4812 CERTIFICATE OF DEATH

04790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5112 Wessling Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD P. McDEVITT				4. DATE OF DEATH April 20, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1879	
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 1 Days 8		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof reader				10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Martin McDevitt				14. MOTHER'S MAIDEN NAME Florence Sewall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Grace M. Andrews, Saul Rd. Beth. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, terminal 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Carcinoma of pancreas DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Diabetes Mellitus 260X 2) Arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 10, 1948 to April 20, 1958 , that I last saw the deceased alive on April 20, 1958 , and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Angle				ADDRESS (Street, city or town, state) 5009 Del Ray Ave., Bethesda, Md.			
DATE SIGNED 4/20/58							
PHYSICIAN'S NAME (Type) Robert G. Angle				5009 DelRay Ave., Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/58		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE APR 23 '58							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 23 1958

RECEIVED

4813 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb 62 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tallahassee 48x-3			
f. STREET ADDRESS Route #2, Box 601				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hayden Middle James Last McKenzie				4. DATE OF DEATH Month April Day 30 , Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1914	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Technical Ass't.				10b. KIND OF BUSINESS OR INDUSTRY Public Health		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Hayden McKenzie				14. MOTHER'S MAIDEN NAME Martha Frierson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Yes WW II				16. SOCIAL SECURITY NO. unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Metastases (symptomatic) 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Melanoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 72 Hours 21 Months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from February 27, 1958 , to April 30, 1958 , that I last saw the deceased alive on April 30, 1958 , and that death occurred at 3:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/1/58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland ACTUAL SIGNATURE Dane R. Boggs M.D. PHYSICIAN'S NAME (Type) DANE R. BOGGS, M.D.							
22a. BURIAL, CREMATION, OR OTHER DISPOSITION Burial		22b. DATE THEREOF 5/1/58		22c. NAME OF CEMETERY OR CREMATORY Oakland		22d. LOCATION (City, town, or county) (State) Leon Co., Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE MAY 5 '58		24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in no event within 72 hours after death.

CERTIFICATE OF DEATH

See Back for

1. PLACE OF DEATH		2. DATE OF DEATH		3. TIME OF DEATH	
At Home		April 1, 1918		10:00 AM	
4. NAME OF DECEASED		5. SEX		6. AGE	
John Doe		Male		45	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
Farmer		Heart Disease		Natural	
10. PLACE OF BIRTH		11. DATE OF BIRTH		12. TIME OF BIRTH	
Maryland		April 1, 1873		10:00 AM	
13. NAME OF MOTHER		14. NAME OF FATHER		15. NAME OF SPOUSE	
Jane Doe		John Doe		Mary Doe	
16. NAME OF PREVIOUS SPOUSE		17. NAME OF PREVIOUS SPOUSE		18. NAME OF PREVIOUS SPOUSE	
19. NAME OF PREVIOUS SPOUSE		20. NAME OF PREVIOUS SPOUSE		21. NAME OF PREVIOUS SPOUSE	
22. NAME OF PREVIOUS SPOUSE		23. NAME OF PREVIOUS SPOUSE		24. NAME OF PREVIOUS SPOUSE	
25. NAME OF PREVIOUS SPOUSE		26. NAME OF PREVIOUS SPOUSE		27. NAME OF PREVIOUS SPOUSE	
28. NAME OF PREVIOUS SPOUSE		29. NAME OF PREVIOUS SPOUSE		30. NAME OF PREVIOUS SPOUSE	
31. NAME OF PREVIOUS SPOUSE		32. NAME OF PREVIOUS SPOUSE		33. NAME OF PREVIOUS SPOUSE	
34. NAME OF PREVIOUS SPOUSE		35. NAME OF PREVIOUS SPOUSE		36. NAME OF PREVIOUS SPOUSE	
37. NAME OF PREVIOUS SPOUSE		38. NAME OF PREVIOUS SPOUSE		39. NAME OF PREVIOUS SPOUSE	
40. NAME OF PREVIOUS SPOUSE		41. NAME OF PREVIOUS SPOUSE		42. NAME OF PREVIOUS SPOUSE	
43. NAME OF PREVIOUS SPOUSE		44. NAME OF PREVIOUS SPOUSE		45. NAME OF PREVIOUS SPOUSE	
46. NAME OF PREVIOUS SPOUSE		47. NAME OF PREVIOUS SPOUSE		48. NAME OF PREVIOUS SPOUSE	
49. NAME OF PREVIOUS SPOUSE		50. NAME OF PREVIOUS SPOUSE		51. NAME OF PREVIOUS SPOUSE	
52. NAME OF PREVIOUS SPOUSE		53. NAME OF PREVIOUS SPOUSE		54. NAME OF PREVIOUS SPOUSE	
55. NAME OF PREVIOUS SPOUSE		56. NAME OF PREVIOUS SPOUSE		57. NAME OF PREVIOUS SPOUSE	
58. NAME OF PREVIOUS SPOUSE		59. NAME OF PREVIOUS SPOUSE		60. NAME OF PREVIOUS SPOUSE	
61. NAME OF PREVIOUS SPOUSE		62. NAME OF PREVIOUS SPOUSE		63. NAME OF PREVIOUS SPOUSE	
64. NAME OF PREVIOUS SPOUSE		65. NAME OF PREVIOUS SPOUSE		66. NAME OF PREVIOUS SPOUSE	
67. NAME OF PREVIOUS SPOUSE		68. NAME OF PREVIOUS SPOUSE		69. NAME OF PREVIOUS SPOUSE	
70. NAME OF PREVIOUS SPOUSE		71. NAME OF PREVIOUS SPOUSE		72. NAME OF PREVIOUS SPOUSE	
73. NAME OF PREVIOUS SPOUSE		74. NAME OF PREVIOUS SPOUSE		75. NAME OF PREVIOUS SPOUSE	
76. NAME OF PREVIOUS SPOUSE		77. NAME OF PREVIOUS SPOUSE		78. NAME OF PREVIOUS SPOUSE	
79. NAME OF PREVIOUS SPOUSE		80. NAME OF PREVIOUS SPOUSE		81. NAME OF PREVIOUS SPOUSE	
82. NAME OF PREVIOUS SPOUSE		83. NAME OF PREVIOUS SPOUSE		84. NAME OF PREVIOUS SPOUSE	
85. NAME OF PREVIOUS SPOUSE		86. NAME OF PREVIOUS SPOUSE		87. NAME OF PREVIOUS SPOUSE	
88. NAME OF PREVIOUS SPOUSE		89. NAME OF PREVIOUS SPOUSE		90. NAME OF PREVIOUS SPOUSE	
91. NAME OF PREVIOUS SPOUSE		92. NAME OF PREVIOUS SPOUSE		93. NAME OF PREVIOUS SPOUSE	
94. NAME OF PREVIOUS SPOUSE		95. NAME OF PREVIOUS SPOUSE		96. NAME OF PREVIOUS SPOUSE	
97. NAME OF PREVIOUS SPOUSE		98. NAME OF PREVIOUS SPOUSE		99. NAME OF PREVIOUS SPOUSE	
100. NAME OF PREVIOUS SPOUSE		101. NAME OF PREVIOUS SPOUSE		102. NAME OF PREVIOUS SPOUSE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04792

Reg. Dist. No.

4814

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5610 Warwick Pl.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>McPherson</u> Last <u>McPherson</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>12-28-82</u>		9. AGE (In years last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>navy dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Personal</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Robert McPherson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Spearling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dorothy McPherson -</u> Address <u>Scenic Stn 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO <u></u> causing the underlying cause lost. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>APR 30 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

MD STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 30 1958
BUREAU V. I.

RECEIVED
APR 30 1958
BUREAU V. I.

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is partially filled out with handwritten text.

1. NAME OF DECEASED: [Handwritten Name]

2. SEX: [Handwritten]

3. AGE: [Handwritten]

4. OCCUPATION: [Handwritten]

5. PLACE OF BIRTH: [Handwritten]

6. DATE OF BIRTH: [Handwritten]

7. DATE OF DEATH: [Handwritten]

8. TIME OF DEATH: [Handwritten]

9. PLACE OF DEATH: [Handwritten]

10. CAUSE OF DEATH: [Handwritten]

11. MANNER OF DEATH: [Handwritten]

12. SIGNATURE OF EXAMINER: [Handwritten Signature]

13. TITLE OF EXAMINER: [Handwritten]

14. ADDRESS OF EXAMINER: [Handwritten]

15. CITY AND STATE: [Handwritten]

16. COUNTY: [Handwritten]

17. ZIP CODE: [Handwritten]

18. TELEPHONE: [Handwritten]

19. FAX: [Handwritten]

20. E-MAIL: [Handwritten]

21. OTHER: [Handwritten]

CERTIFICATE OF DEATH

4815

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN 1b 3 Days		d. STREET ADDRESS 4222 River Road, N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last MERRITT		4. DATE OF DEATH Month April Day 15 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 April 1958
9. AGE (In years last birthday) 3		10. IF UNDER 1 YEAR: Months 3 Days 3 Hours 3 Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Handall G. MERRITT		14. MOTHER'S MAIDEN NAME Barbara Frances CALOWOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 7620 IMMEDIATE CAUSE (a) Apnea DUE TO (b) Prematurity (23 week gestation) DUE TO (c) 30 min 3 days CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 30 min 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 April , 19 58 , to 15 April , 19 58 , that I last saw the deceased alive on 14 April , 19 58 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 4-17-58			
ACTUAL SIGNATURE Kenneth W. Sell		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Kenneth W. SELL, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-21-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Chambers, 3072 "M" St. N.W., Washington, D.C.		24a. REC'D BY REGISTRAR DATE APR 18 '58	24b. REGISTRAR'S SIGNATURE Alfred

2051203XV0

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

APR, 18 1953

RECEIVED

4708

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>4 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7911 Garland Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LORANE</u> Middle <u>ASHMAN</u> Last <u>MIERLEY</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/8/83</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>			
13. FATHER'S NAME <u>Frank Mierley</u>				14. MOTHER'S MAIDEN NAME <u>Anna Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Edith Peterson, Dtr. 7911 Garland Ave.</u>				Address <u>Takoma Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 2</u> , 19 <u>58</u> , and that death occurred at <u>4:20 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest A. Sarao</u> M.D.				ADDRESS (Street, city or town, state) <u>7006 NEW HAMPSHIRE Ave</u> DATE SIGNED <u>April 9, 1958</u>			
PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO</u>				<u>TAKOMA PARK 12, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>8434 Ga. Ave. Sil. Sp. Md.</u>		24a. REC'D BY REGISTRAR <u>APR 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alf Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 7 1958

RECEIVED

4816

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>56</u> <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>433 Southwest Dr.</u>				d. STREET ADDRESS <u>433 Southwest Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>F.</u> Last <u>MOORE, SR</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/13/1892</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>21</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hardware</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>		17. INFORMANT <u>Eleanor I Moore</u>		Address <u>same as 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>442 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive-Cardio-renal</u> DUE TO (c) <u>vascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>11 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 13, 1947</u> to <u>April 4, 1958</u> , that I last saw the deceased alive on <u>April 4, 1958</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lester W. Harris</u>		M.D. <u>10/11</u>		ADDRESS (Street, city or town, state) <u>Colesville Rd</u>		DATE SIGNED <u>4-4-58</u>	
PHYSICIAN'S NAME (Type) <u>Lester W. Harris</u>		10111 Colesville, Re. Silver Spring					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Quel...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

BUREAU V. S.

APR 7 1958

RECEIVED

4817

CERTIFICATE OF DEATH

04796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle C Last Morris		4. DATE OF DEATH Month April Day 10 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1891
9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) USA - Penn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William McEnaney		14. MOTHER'S MAIDEN NAME Ida May Hepp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Spencer Address Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart Disease 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 5 yrs 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1958, to 10 April 1958, that I last saw the deceased alive on 9 April 1958, and that death occurred at 5:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11134 Georgia Ave. Silver Spring, Md DATE SIGNED 4/10/58			
ACTUAL SIGNATURE Merton L. White M.D.		PHYSICIAN'S NAME (Type) Merton L. White	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/58	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR APR 14 '58 24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

02 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G228 5-15-58 et

4818

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u> c. LENGTH OF STAY IN TB <u>Washington</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47x-3</u> d. STREET ADDRESS <u>4616-48th., St., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>MOWBRAY</u> Last <u>MOWBRAY</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>	IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Poole</u>		14. MOTHER'S MAIDEN NAME <u>Mary Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Rest Home records</u>	
17. INFORMANT <u>Rest Home records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arterio-sclerotic Heart Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>1+yr.</u> <u>1+yr.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1, 1956</u> to <u>April 27, 1958</u> , that I last saw the deceased alive on <u>April 24, 1958</u> , and that death occurred on <u>April 27, 1958</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. H. Richwine</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5522 Chestnut Ave</u> <u>Cherry Chase 15, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. H. RICHWINE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/30/58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Pa</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Robert Smith</u>

1918 CERTIFICATE OF DEATH

THE STATE OF MARYLAND

NAME OF DECEASED <i>George William Jones</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF DEATH <i>April 10, 1918</i>		PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart failure</i>		DISEASE OR INJURY <i>Myocarditis</i>		SYMPTOMS <i>Shortness of breath, swelling of feet</i>		TREATMENT <i>Medicine</i>		PREVIOUS ILLNESS <i>None</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		SIGNATURE OF DECEASED <i>George W. Jones</i>		SIGNATURE OF FUNERAL DIRECTOR <i>Mr. Brown</i>		SIGNATURE OF CLERK <i>Miss White</i>		SIGNATURE OF REGISTRAR <i>Mr. Green</i>	
DATE OF SIGNATURE <i>April 12, 1918</i>		DATE OF SIGNATURE <i>April 12, 1918</i>		DATE OF SIGNATURE <i>April 12, 1918</i>		DATE OF SIGNATURE <i>April 12, 1918</i>		DATE OF SIGNATURE <i>April 12, 1918</i>		DATE OF SIGNATURE <i>April 12, 1918</i>	

BUREAU V. 2

APR 30 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4709

CERTIFICATE OF DEATH

04798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gilbert Drayton Mulkey</u>				4. DATE OF DEATH <u>4-6-1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-84</u>	
9. AGE (In years lost birthday) <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Steel Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Joseph Mulkey</u>				14. MOTHER'S MAIDEN NAME <u>Missouri Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>420.1</u>			
17. INFORMANT <u>Hospital Records</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete Heart Block</u> DUE TO <u>Cardiac Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Embolism (liquefaction of aorta)</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Mar. 24</u> , 19 <u>58</u> , to <u>4-6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Apr. 5</u> , 19 <u>58</u> , and that death occurred at <u>4:50 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul V. Starr</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave.</u>			
DATE SIGNED <u>4-6-58</u>				PHYSICIAN'S NAME (Type) <u>Takoma Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Mem PK.</u>		22d. LOCATION (City, town, or county) (State) <u>Bluefield, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers, Co. Riverdale, Md.</u>				24. REC'D BY REGISTRAR <u>APR 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04799

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

4819

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write "RURAL" and give nearest town)

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a. m.
p. m.

Month, Day, Year

19

20d. INJURY OCCURRED
While ☐ Not while
of work ☐ of work ☐

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. City or town

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐. Accident ☐. Suicide ☒. Homicide ☐. Undetermined manner ☐

ACTUAL
SIGNATURE

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

4-21-58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

Burial

4/24/58

Gate of Heaven

Silver Spring, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Robert A. Pumphrey

Bethesda, Maryland

DATE

APR 25 1958

Redeavor

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

BUREAU V. S.

APR 25 1938

RECEIVED

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		RELIGION	
MARRIAGE		OCCUPATION	
EDUCATION		MILITARY SERVICE	
PREVIOUS ILLNESS		MANNER OF DEATH	
SIGNATURE OF EXAMINER		DATE	
OFFICE		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

4724

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>24 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Falls Rd</u>				d. STREET ADDRESS <u>1 Falls Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Georgina Surber Mungen</u> First Middle Last				4. DATE OF DEATH Month <u>Apr</u> Day <u>3</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15 76</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min. <u>58</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va</u>		11. BIRTHPLACE (State or foreign country) <u>M. S. G.</u>		12. CITIZEN OF WHAT COUNTRY? <u>M. S. G.</u>	
13. FATHER'S NAME <u>Geo. H. Surber</u>				14. MOTHER'S MAIDEN NAME <u>Rose Hillman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Roscoe Miller Bethesda, Md</u> Address <u>4836 Brookbrook Dr</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>2 hr.</u> (a), stating the underlying cause last. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-3-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 7 58</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.



BUREAU V. 3

APR 7 1958

RECEIVED

4820

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1500 Arlington Blvd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jean Middle Murray Last NIELSEN				4. DATE OF DEATH Month April Day 15 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Oct. 1904		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manicurist		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Percy Sudsbury				14. MOTHER'S MAIDEN NAME Margaret Goudet			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) James NIELSEN (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 April , 19 58 , to 15 April , 19 58 , that I last saw the deceased alive on 15 April , 19 58 , and that death occurred at 8:55A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert G. Muth M.D. U.S. Naval Hospital, Bethesda, Md. 4-16-58							
ACTUAL SIGNATURE Robert G. Muth M.D. U.S. Naval Hospital, Bethesda, Md. 4-16-58							
PHYSICIAN'S NAME (Type) Robert G. MUTH LT MC USN U.S. Naval Hospital, Bethesda, Md. 4-16-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Chambers, 3043 "M" Street, N.W. Washington, D.C.				24a. REC'D BY REGISTRAR APR 18 '58		24b. REGISTRAR'S SIGNATURE W. F. Smith	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

212

BUREAU V. S.

APR 18 1958

RECEIVED

4821 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 70 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Box 302			
3. NAME OF DECEASED (Type or print) First Stephen Middle Emery Last Orosz				4. DATE OF DEATH Month April Day 20 , Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 29, 1950		9. AGE (In years last birthday) 7 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Emery S. Orosz				14. MOTHER'S MAIDEN NAME Mary Sepety			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 9, 1958 , to April 20, 1958 , that I last saw the deceased alive on April 20, 1958 , and that death occurred at 8:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Kurt W. Kohn				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) Kurt W. Kohn, M. D.				The National Institutes of Health			
				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-Transit		4-24-58		St. Marys Greek Catholic		Windber, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE APR 23 '58	
						24b. REGISTRAR'S SIGNATURE W. Beach	

MEDICAL CERTIFICATION

2

50

I

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 10

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John A. Smith		Male		45		April 23, 1958		Los Angeles, California	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Natural		Home	
Date of Birth		Date of Death		Time of Death		Time of Day		Time of Year	
April 15, 1913		April 23, 1958		10:15 AM		10:15 AM		April	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Death Investigator	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

APR 23 1958

RECEIVED

Robert W. Humphrey
Bartholomew, No. 1-25-58
St. Mary's Greek Catholic
Windward
The National Institute of Health
The National Cancer
The National Institute of Health
The National Cancer

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04803

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN 1b

3 1/2 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

md

b. COUNTY

montg

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

56 Silver Spring

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3307 Fairbury Dr.

d. STREET ADDRESS

13307 Fairbury Dr.

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

George Christie Otte

4. DATE
OF
DEATH

Apr 11 1958

5. SEX

male

6. COLOR OF RACE

white

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

B. DATE OF BIRTH

1901

9. AGE (In years
last birthday)

55 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

auto

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF WHAT COUNTRY?

U.S.C.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

yes

WW #2

16. SOCIAL SECURITY NO.

217-05-7847

17. INFORMANT

Address

Sadie Otte (wife) Same # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m.
p. m.20d. INJURY OCCURRED
While at work ☐ Not while
at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my
opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Frank J. Braschant

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

FRANK J. BRASCHANT

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

Apr 12 - 1958

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

4/15/58

22c. NAME OF CEMETERY OR CREMATORY

Arlington Nat'l. Cemetery

22d. LOCATION (City, town, or county)

Arlington, Virginia

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Warner E. Pumphrey

ADDRESS

Silver Spring, Md.

24a. REC'D BY REGISTRAR

DATE APR 15 1958

24b. REGISTRAR'S SIGNATURE

W. E. Pumphrey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 15 1958

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT



4823

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47x-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 5411 Nebraska Ave. N. W.	
3. NAME OF DECEASED (Type or print) First Florence Middle E. Last Painter		4. DATE OF DEATH Month April Day 27 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/2/83
9. AGE (In years last birthday) yrs. 74		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME EDWARD HAUSER		14. MOTHER'S MAIDEN NAME Henrietta XXXXX RAL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Son Rolen H. Painter		Address 5411 Nebraska Ave, NW Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE, LEFT 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1956 to April 27, 1958 , that I last saw the deceased alive on April 26, 1958 , and that death occurred at 4:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5000 Reno Rd NW DATE SIGNED 4/27/58			
ACTUAL SIGNATURE W. Fleet Lockett		M.D. 5000 Reno Rd NW	
PHYSICIAN'S NAME (Type) W. FLEET LUCKETT		5000 Reno Rd., N.W., Washington, D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-30-58	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE APR 30 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

Item 14 Film G228 5-9-58 at
4824 CERTIFICATE OF DEATH

04805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4816 Dorset Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THEODOSIA</u> Middle <u>W.</u> Last <u>PALMER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1894</u>
9. AGE (In years last birthday) yrs. <u>63</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maret School</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. Walter</u>		14. MOTHER'S MAIDEN NAME <u>Amalie Ann Hutton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>577-48-7471</u>	
17. INFORMANT <u>Richard C. Palmer, (Son)</u>		Address <u>Pompton Plains, N.J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolus</u> DUE TO (b) <u>Endometrial carcinoma</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr. 26</u> , 19 <u>58</u> , to <u>Apr. 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Apr. 26</u> , 19 <u>58</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas L. Hartman</u>		ADDRESS (Street, city or town, state) <u>1834 Eye St., Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas L. Hartman</u>		DATE SIGNED <u>4/26/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>4/28/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chevy Chase Funeral Home</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>		ADDRESS <u>5103 N. ...</u>	24a. REC'D BY REGISTRAR <u>PR 30 '58</u>
		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4825 Item 9 BILM 228 5-12-58 at
CERTIFICATE OF DEATH

04806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b 14 Mo. about		1615.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home		d. STREET ADDRESS 6002 43rd Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle EUGENIA Last PARLETT		4. DATE OF DEATH Month APRIL Day 20 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Thomas J. Linthicum		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Asbury Methodist Home Gaithersburg, Md.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension + (c) arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 yr 10 yr
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9-25 , 19 7 , to 4-20 , 19 58 , that I last saw the deceased alive on 4-16 , 19 58 , and that death occurred at 7:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4208 Anthony St. Hyattsville, Md. DATE SIGNED 4-20-58 ACTUAL SIGNATURE Sarah E. Glover M.D. PHYSICIAN'S NAME (Type) Sarah E. Glover		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/13/58	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR APR 23 '58
ADDRESS		24b. REGISTRAR'S SIGNATURE W. E. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4826 CERTIFICATE OF DEATH

Reg. Dist. No.

04807

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Le Deau Gardens		d. STREET ADDRESS 9909 Thornwood Rd.	
3. NAME OF DECEASED (Type or print) First Victor Middle Cox Last Pedersen		4. DATE OF DEATH Month April Day 9 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/1867
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 4 Days 24	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician, retired		10b. KIND OF BUSINESS OR INDUSTRY Doctor	11. BIRTHPLACE (State or foreign country) New York City, N. Y.
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Joseph Silvey Pedersen	
14. MOTHER'S MAIDEN NAME Victoria Cox		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter Mrs. Walter P. Warendorff Address 9909 Thornwood Rd. Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO Arteriosclerosis; Dentized DUE TO Serility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3-4 days yrs. yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 10, 1956 , to 4/9/58 , 19... that I last saw the deceased alive on 4/9/58 , 19... and that death occurred at 9:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kensington, MD DATE SIGNED 4/9/58 ACTUAL SIGNATURE Samuel Allen M.D. PHYSICIAN'S NAME (Type) SAMUEL ALLEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 4/14/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR APR 14 '58	24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04808

Reg. Dist. No.

4827

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		
c. LENGTH OF STAY IN Tb <u>21 yr</u>			d. STREET ADDRESS <u>4612 Harrison St.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4612 Harrison St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha Steward Phillips</u>			4. DATE OF DEATH Month Day Year <u>Apr 19 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 19, 1901</u>		9. AGE (In years last birthday) <u>56 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Phone maker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John W. Steward</u>			14. MOTHER'S MAIDEN NAME <u>Martha (SAFFORD) Steward</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Geo R Phillips - husband</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardio-renal disease</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-19-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL OR CREMATION (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>4/20/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Branchville, New Jersey</u>	
22d. LOCATION (City, town, or county)		22e. (State)		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley Sons</u>		ADDRESS <u>Washington, D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



BUREAU V. 2

APR 21 1930

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4828

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
c. LENGTH OF STAY IN 1b <u>7 mo</u>				d. STREET ADDRESS <u>12619 Farnell Dr</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12619 Farnell Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Walter Taylor Poetzman</u>				4. DATE OF DEATH <u>apr 19 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-5-1905</u>	
9. AGE (in years last birthday) <u>52 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>John H. Poetzman</u>				14. MOTHER'S MAIDEN NAME <u>Cinnie Hughes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Josephine Poetzman (wife)</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2044 Congestive heart failure</u> DUE TO (b) <u>Luxuria</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-19-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u></u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hanlon Funeral Home, Wash. 11, D.C.</u>				24. REC'D BY REGISTRAR <u>DATE APR 22 '58</u>		25. REGISTRAR'S SIGNATURE <u>Al Seach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROB STATE
HEALTH DEPT
2

RECEIVED
APR 24 1953

RECEIVED
APR 24 1953
BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: _____
AGE: _____ SEX: _____
RACE: _____
DATE OF DEATH: _____
PLACE OF DEATH: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE OF MEDICAL EXAMINER: _____
DATE: _____

CERTIFICATE OF DEATH

4829

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland Ohio b. COUNTY XXXXXXXXXX Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park Dayton 72X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1740 King Avenue Anderson Court	
3. NAME OF DECEASED (Type or print) First Mark Middle Alvin Last POFF		4. DATE OF DEATH Month April Day 16 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 April 1958
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ralph Mark POFF		14. MOTHER'S MAIDEN NAME Carol F. PRYOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Ralph M. POFF (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia DUE TO 7545 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart Disease DUE TO 3 days (c) 10 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Complete stenosis of Pulmonary artery - Overriding Aorta &			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patent Ductus	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 15 April 1958 , to 16 April 1958 , that I last saw the deceased alive on 16 April 1958 , and that death occurred at 2:21 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth W. Sell		ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 4-17-58	
PHYSICIAN'S NAME (Type) Kenneth W. Sell, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-22-58	22c. NAME OF CEMETERY OR CREMATORY Woodland Cemetery	22d. LOCATION (City, town, or county) (State) Dayton, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR APR 21 '58	
ADDRESS R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24b. REGISTRAR'S SIGNATURE [Signature]	

2051201XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. S.

APR 21 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4830

CERTIFICATE OF DEATH

04811

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1823 Benson Street			
3. NAME OF DECEASED (Type or print) Deborah First (None) Middle Pollock Last				4. DATE OF DEATH April Month 3 Day 19 Year 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 April 1936	
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Typist				10b. KIND OF BUSINESS OR INDUSTRY Private Industry		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Leon Pollock				14. MOTHER'S MAIDEN NAME Sally Zlotnick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO 229x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal debility (c) Testicular carcinoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 1 week 5 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 9, 1958 , to April 3, 1958 , that I last saw the deceased alive on April 3, 1958 , and that death occurred at 5:53 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Allen D. Goodman				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/3/58			
PHYSICIAN'S NAME (Type) Allen D. Goodman, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF April 4, 1958		22c. NAME OF CEMETERY OR CREMATORY MONTEFIORE		22d. LOCATION (City, town, or county) (State) PHILADELPHIA PENNA	
23. FUNERAL DIRECTOR'S SIGNATURE F. Basch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE W. L. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

RECEIVED
BUREAU V. E.

BUREAU V. E.

APR 7 1958

RECEIVED

4831 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Louisiana</u> b. COUNTY <u>Calcasieu</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maplewood</u>	
c. LENGTH OF STAY IN 1b <u>69 days</u>		d. STREET ADDRESS <u>115 Madison Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USN Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Winnie</u> Middle <u>Rose</u> Last <u>PRINE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 October 1933</u>
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hous ewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>BOLlich, Peter J.</u>		14. MOTHER'S MAIDEN NAME <u>FRYE, Lottie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT (Husband) <u>Bennon L. PRINE</u>		Address <u>Falls Church, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Rectum with Metastasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>16 February</u> , 19 <u>58</u> , to <u>26 April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>26 April</u> , 19 <u>58</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>R. J. Cales</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>R. J. CALES, LCDR MC USN</u>		<u>U. S. Naval Hospital, Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Unknown</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mowata</u>	22d. LOCATION (City, town, or county) (State) <u>Eunice, Louisiana</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Apr 29 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

BUREAU V. S.

APR 29 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4710

CERTIFICATE OF DEATH

04814

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u> d. STREET ADDRESS <u>1611 Thayer Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Ellwood</u> Last <u>Ray</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1958</u>													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/28/20</u>		9. AGE (In years last birthday) <u>37</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>James Ray</u>				14. MOTHER'S MAIDEN NAME <u>Beatrice Bowman</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW2</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-18-7596</u>		17. INFORMANT <u>Washington San & Hosp. Records</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u> <u>322.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcoholism</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>54 hours</u>																	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>4:19</u> p. m. <u>1958</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>4/19/58</u> , to <u>4/21/58</u> , that I last saw the deceased alive on <u>4/21/58</u> , and that death occurred at <u>7:40 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>925 Pershing Dr. Silver Spring, Md.</u> DATE SIGNED _____																	
ACTUAL SIGNATURE <u>Thomas G. Edison M.D.</u>				PHYSICIAN'S NAME (Type) <u>THOMAS G. EDISON</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brookeville Methodist Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brookeville, Md.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				24a. REC'D BY REGISTRAR DATE <u>APR 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>											

CERTIFICATE OF DEATH

1110

BUREAU V. S.

APR 24 1933

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04815

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1615.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>		d. STREET ADDRESS <u>6612 - 24th Place</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Marie Remington</u>		4. DATE OF DEATH Month Day Year <u>April - 11 - 19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Paul McKay</u>		14. MOTHER'S MAIDEN NAME <u>-</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>MISS MILDRED L. REMINGTON - same</u>	
17. INFORMANT <u>Miss Mildred L. Remington - same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) <u>hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Apr 11 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 15, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Maryland</u>	
24a. REC'D BY REGISTRAR <u>APR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb...</u>	

BUREAU V. M.

8361

RECEIVED
JUL 4 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4712

CERTIFICATE OF DEATH

04816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3645-15th St. Bethesda 14</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. STREET ADDRESS <u>5 Russett Rd</u>	
3. NAME OF DECEASED (Type or print) <u>David B. Bobbitt</u> First Middle Last		4. DATE OF DEATH <u>April 29</u> Month Day Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1951</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Allen Charles Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Blain Mapp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Record</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Atelctasis</u> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from 4-28, 1958, to 4-29, 1958, that I last saw the deceased alive on 4-29, 1958, and that death occurred at 7:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Bennett A. Robin M.D. ADDRESS (Street, city or town, state) Silver Spring Md. DATE SIGNED May 5 '58

PHYSICIAN'S NAME (Type) Bennett A. Robin M.D. 8723 Piney Branch Rd. Silver Spring Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>4-30-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital</u>	22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Brown</u> ADDRESS <u>Washington Sanitarium and Hospital</u>		24a. REC'D BY REGISTRAR <u>May 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. E. Brown</u>

2075241XV3



4832

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 35 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Norman Middle Francis Last Ridgeway				4. DATE OF DEATH Month April Day 23 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1935	
9. AGE (In years last birthday) yrs. 23		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman				10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Wesley N. Ridgeway				14. MOTHER'S MAIDEN NAME Mildred Downey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 230-50-9205		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic insufficiency DUE TO 178x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Herpes carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 hours 11 mo.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 19, 19 58 , to April 23, 19 58 , that I last saw the deceased alive on April 23, 1958 , and that death occurred at 5:08P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 4/24/58 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Lawrence Schlachter				PHYSICIAN'S NAME (Type) Lawrence Schlachter, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4-26-58		Mt. Comfort Cem.		Alexandria	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Demme				ADDRESS Alexandria Va		24a. REC'D BY REGISTRAR DATE APR 28 '58	
24b. REGISTRAR'S SIGNATURE W. Demme							

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		35		Jan 1, 1900		New York City		New York City		Heart Disease		Natural	
Occupation		Married		Single		Widowed		Divorced		Married		Date of Death		Place of Death	
Teacher		Yes		No		No		No		Yes		April 15, 1935		New York City	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

The Medical Examiner
The Medical Examiner
The Medical Examiner

APR 15 1935

BUREAU V. S.

APR 28 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4833

Item 14 FilmG228 5-15-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

04818

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47x-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>5236-42nd St NW</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick John Ritter</u>				4. DATE OF DEATH Month Day Year <u>April 19 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1885</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Architectural Eng</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry B. Ritter</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Maria Elizabeth Buchlein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>wife</u> Address <u>Same as above</u> <u>Mrs Sowella Ritter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia</u> DUE TO (c) <u>Nephrosclerosis, severe</u>						INTERVAL BETWEEN ONSET AND DEATH <u>approx 4 da</u> <u>1 week</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> NOT while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April 6, 1958</u> , to <u>April 19, 1958</u> , that I last saw the deceased alive on <u>April 19, 1958</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				ADDRESS (Street, city or town, state) <u>3921 Ingomar St NW, Wash 15 D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				DATE SIGNED <u>4-19-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/21/58</u>		<u>Parlous, Emm</u>		<u>Rockville Pike Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home Wisconsin</u>				ADDRESS <u>5103</u>		24a. REC'D BY REGISTRAR	
				DATE <u>APR 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Reberich</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. DATE OF DEATH	
9. PLACE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN		16. SIGNATURE OF CLERK	
17. SIGNATURE OF CHURCH CLERK		18. SIGNATURE OF BURIAL OFFICER		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CEMETERY	
21. SIGNATURE OF CORONER		22. SIGNATURE OF JURY		23. SIGNATURE OF JUDGE		24. SIGNATURE OF DISTRICT ATTORNEY	
25. SIGNATURE OF COUNTY CLERK		26. SIGNATURE OF STATE CLERK		27. SIGNATURE OF U.S. DEPT. OF HEALTH		28. SIGNATURE OF U.S. DEPT. OF JUSTICE	
29. SIGNATURE OF U.S. DEPT. OF AGRICULTURE		30. SIGNATURE OF U.S. DEPT. OF COMMERCE		31. SIGNATURE OF U.S. DEPT. OF EDUCATION		32. SIGNATURE OF U.S. DEPT. OF INTERIOR	
33. SIGNATURE OF U.S. DEPT. OF NAVY		34. SIGNATURE OF U.S. DEPT. OF WAR		35. SIGNATURE OF U.S. DEPT. OF TREASURY		36. SIGNATURE OF U.S. DEPT. OF TRANSPORTATION	
37. SIGNATURE OF U.S. DEPT. OF POSTS AND MARITIME AFFAIRS		38. SIGNATURE OF U.S. DEPT. OF COAST AND GEODYSY		39. SIGNATURE OF U.S. DEPT. OF MINES		40. SIGNATURE OF U.S. DEPT. OF AERONAUTICS	
41. SIGNATURE OF U.S. DEPT. OF ARMY		42. SIGNATURE OF U.S. DEPT. OF NAVY		43. SIGNATURE OF U.S. DEPT. OF AIR FORCE		44. SIGNATURE OF U.S. DEPT. OF SPACE	
45. SIGNATURE OF U.S. DEPT. OF DEFENSE		46. SIGNATURE OF U.S. DEPT. OF ENERGY		47. SIGNATURE OF U.S. DEPT. OF HEALTH AND HUMAN SERVICES		48. SIGNATURE OF U.S. DEPT. OF AGRICULTURE	
49. SIGNATURE OF U.S. DEPT. OF COMMERCE		50. SIGNATURE OF U.S. DEPT. OF EDUCATION		51. SIGNATURE OF U.S. DEPT. OF INTERIOR		52. SIGNATURE OF U.S. DEPT. OF JUSTICE	
53. SIGNATURE OF U.S. DEPT. OF LABOR		54. SIGNATURE OF U.S. DEPT. OF TRANSPORTATION		55. SIGNATURE OF U.S. DEPT. OF AERONAUTICS		56. SIGNATURE OF U.S. DEPT. OF SPACE	
57. SIGNATURE OF U.S. DEPT. OF DEFENSE		58. SIGNATURE OF U.S. DEPT. OF ENERGY		59. SIGNATURE OF U.S. DEPT. OF HEALTH AND HUMAN SERVICES		60. SIGNATURE OF U.S. DEPT. OF AGRICULTURE	
61. SIGNATURE OF U.S. DEPT. OF COMMERCE		62. SIGNATURE OF U.S. DEPT. OF EDUCATION		63. SIGNATURE OF U.S. DEPT. OF INTERIOR		64. SIGNATURE OF U.S. DEPT. OF JUSTICE	
65. SIGNATURE OF U.S. DEPT. OF LABOR		66. SIGNATURE OF U.S. DEPT. OF TRANSPORTATION		67. SIGNATURE OF U.S. DEPT. OF AERONAUTICS		68. SIGNATURE OF U.S. DEPT. OF SPACE	
69. SIGNATURE OF U.S. DEPT. OF DEFENSE		70. SIGNATURE OF U.S. DEPT. OF ENERGY		71. SIGNATURE OF U.S. DEPT. OF HEALTH AND HUMAN SERVICES		72. SIGNATURE OF U.S. DEPT. OF AGRICULTURE	
73. SIGNATURE OF U.S. DEPT. OF COMMERCE		74. SIGNATURE OF U.S. DEPT. OF EDUCATION		75. SIGNATURE OF U.S. DEPT. OF INTERIOR		76. SIGNATURE OF U.S. DEPT. OF JUSTICE	
77. SIGNATURE OF U.S. DEPT. OF LABOR		78. SIGNATURE OF U.S. DEPT. OF TRANSPORTATION		79. SIGNATURE OF U.S. DEPT. OF AERONAUTICS		80. SIGNATURE OF U.S. DEPT. OF SPACE	
81. SIGNATURE OF U.S. DEPT. OF DEFENSE		82. SIGNATURE OF U.S. DEPT. OF ENERGY		83. SIGNATURE OF U.S. DEPT. OF HEALTH AND HUMAN SERVICES		84. SIGNATURE OF U.S. DEPT. OF AGRICULTURE	
85. SIGNATURE OF U.S. DEPT. OF COMMERCE		86. SIGNATURE OF U.S. DEPT. OF EDUCATION		87. SIGNATURE OF U.S. DEPT. OF INTERIOR		88. SIGNATURE OF U.S. DEPT. OF JUSTICE	
89. SIGNATURE OF U.S. DEPT. OF LABOR		90. SIGNATURE OF U.S. DEPT. OF TRANSPORTATION		91. SIGNATURE OF U.S. DEPT. OF AERONAUTICS		92. SIGNATURE OF U.S. DEPT. OF SPACE	
93. SIGNATURE OF U.S. DEPT. OF DEFENSE		94. SIGNATURE OF U.S. DEPT. OF ENERGY		95. SIGNATURE OF U.S. DEPT. OF HEALTH AND HUMAN SERVICES		96. SIGNATURE OF U.S. DEPT. OF AGRICULTURE	
97. SIGNATURE OF U.S. DEPT. OF COMMERCE		98. SIGNATURE OF U.S. DEPT. OF EDUCATION		99. SIGNATURE OF U.S. DEPT. OF INTERIOR		100. SIGNATURE OF U.S. DEPT. OF JUSTICE	

BUREAU V. S.

APR 22 1958

RECEIVED

4834

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16 15.2			
f. STREET ADDRESS 5104 Emerson Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Alfred Last Roberts				4. DATE OF DEATH Month April Day 8 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 23, 1885	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72		IF UNDER 24 HRS. Months 72 Days 72 Hours 72 Min. 72			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Scott Roberts				14. MOTHER'S MAIDEN NAME Amanda Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 578-05-7809		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma of bladder DUE TO (c) 21 ms							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypocauldosteronism							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 29, 19 58 , to April 8, 19 58 , that I last saw the deceased alive on April 8, 19 58 , and that death occurred at 8:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lawrence Schlachter M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/8/58			
PHYSICIAN'S NAME (Type) Lawrence Schlachter, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE APR 11 1958	
				24b. REGISTRAR'S SIGNATURE Clifford			

41

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

4835 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>4005 FESSENDEN ST. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>ANTHONY</u> Last <u>ROCCA</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 7 1958</u>	9. AGE (In years lost birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK ROCCA</u>				14. MOTHER'S MAIDEN NAME <u>HELEN MAXINE BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MOTHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Erythroblastosis foetalis</u> <u>770.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rh incompatibility - (Mother Rh negative)</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 7</u> , 19 <u>58</u> , to <u>April 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>58</u> , and that death occurred at <u>1:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4201 Fessenden St N.W. Washington D.C.</u> DATE SIGNED <u>4-10-58</u>							
ACTUAL SIGNATURE <u>P.P. Andrews M.D.</u>		M.D. <u>4201 Fessenden St N.W. Washington D.C.</u>					
PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Lovettsville, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Henies Co</u>				ADDRESS <u>2901-14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074387XV5

CERTIFICATE OF DEATH

NAME OF DECEASED FRANK ROSS		AGE 45		SEX M		RACE W		DATE OF BIRTH 1912		PLACE OF BIRTH NEW YORK	
DATE OF DEATH 1939		TIME OF DEATH 10:30 AM		PLACE OF DEATH JOHNS HOPKINS HOSPITAL		CITY BALTIMORE		STATE MD		COUNTRY USA	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DISEASE OR INJURY ANGINA PECTORIS		IMMEDIATE CAUSE MYOCARDIAL INFARCTION		INTERMEDIATE CAUSE ARTERIOSCLEROSIS		FINAL CAUSE HYPERTENSION	
SIGNATURE OF PHYSICIAN DR. J. H. ROSS		SIGNATURE OF WITNESSES DR. J. H. ROSS		SIGNATURE OF DECEASED FRANK ROSS		SIGNATURE OF NEXT OF KIN MRS. J. H. ROSS		SIGNATURE OF BURIAL OFFICIAL JOHN J. ROSS		SIGNATURE OF REGISTRAR JOHN J. ROSS	
DATE OF INTERMENT 1939		TIME OF INTERMENT 10:30 AM		PLACE OF INTERMENT JOHNS HOPKINS HOSPITAL		CITY BALTIMORE		STATE MD		COUNTRY USA	
DATE OF BURIAL 1939		TIME OF BURIAL 10:30 AM		PLACE OF BURIAL JOHNS HOPKINS HOSPITAL		CITY BALTIMORE		STATE MD		COUNTRY USA	

BUREAU V. E.
APR 14 1939

RECEIVED

04821

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>		c. LENGTH OF STAY IN 1b <u>10 hours.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>(N.M.N.)</u> Last <u>Rodwell</u>		4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-19-79</u>
9. AGE (In years lost birthday) <u>78 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(Retired)</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Rodwell</u>		14. MOTHER'S MAIDEN NAME <u>Emma Halton.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>579-42-6097</u>	
17. INFORMANT <u>Mr. Lawrence W. Mack</u>		Address <u>7701 Georgia Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 14, 1958</u> , to <u>April 15, 1958</u> , that I last saw the deceased alive on <u>April 15, 1958</u> , and that death occurred at <u>7:40</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harmon Bankhead</u>		DATE SIGNED <u>4/15/58</u>	
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>		ADDRESS (Street, city or town, state) <u>9241 Col. Blvd.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Reynoldsville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Reynoldsville, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. E. Humphrey</u>		24a. REC'D BY REGISTRAR DATE <u>APR 17 '58</u>	
ADDRESS <u>8134 Georgia Ave. Silver Spring, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

APR 17 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4836

04822

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, MD		c. LENGTH OF STAY IN 1b 7 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, MARYLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN HOSPITAL				d. STREET ADDRESS 4404 Fairfield Road Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Getzendanner Last Rohr				4. DATE OF DEATH Month April Day 15 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1908	
9. AGE (In years last birthday) 50 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Winton Getzendanner			
14. MOTHER'S MAIDEN NAME Anna M. Gemmill				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate poisoning (Seconal) 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of stomach and intestinal tract						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED April 15, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4/16/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR APR 17 '58	
24b. REGISTRAR'S SIGNATURE Over							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

APR 17 1958

RECEIVED

Registrar of Births and Deaths
General Hill Building
Baltimore, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4837

CERTIFICATE OF DEATH

04823

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head 08X-2	
3. NAME OF DECEASED (Type or print) First Kathleen Middle Faye Last RONAN		4. DATE OF DEATH Month April Day 30 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 April 1958
9. AGE (In years last birthday) yrs. 7 Months 8 Days 55		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lawrence Edward RONAN		14. MOTHER'S MAIDEN NAME Fernande RIVARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Lawrence E. RONAN (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) Prematuriey (2260 gms.) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 28 April , 19 58 , to 30 April , 19 58 , that I last saw the deceased alive on 30 April , 19 58 , and that death occurred at 12:30A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth W. Sell		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Kenneth W. Sell, LT, MC, USN		DATE SIGNED 4-30-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-5-58	
22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery		22d. LOCATION (City, town, or county) (State) Lewiston, Maine	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24. REC'D BY REGISTRAR W. Leach	

2051262XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		New York City		New York City		Heart Disease		Jan 15, 1945		10:00 AM		New York City		John Doe, M.D.		John Doe, M.D.	
Occupation		Marital Status		Color		Height		Weight		Education		Religion		Previous Illnesses		Alcohol Consumption		Tobacco Use		Mental Condition		Other Remarks	
Teacher		Married		White		5' 10"		170 lbs		High School		Catholic		None		Occasional		Daily		Normal		None	
Signature of Informant		Relationship to Deceased		Address of Informant		City		State		Zip		Telephone		Signature of Informant		Relationship to Deceased		Address of Informant		City		State	
John Doe		Son		123 Main St		New York		NY		10001		555-1234		John Doe		Son		123 Main St		New York		State	
Signature of Registrar		Relationship to Deceased		Address of Registrar		City		State		Zip		Telephone		Signature of Registrar		Relationship to Deceased		Address of Registrar		City		State	
John Doe		Son		123 Main St		New York		NY		10001		555-1234		John Doe		Son		123 Main St		New York		State	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4838 CERTIFICATE OF DEATH

04824
215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1425 Congress Place, S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Michelle Middle (nmn) Last RUSH		4. DATE OF DEATH Month April Day 17 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 April 1958
9. AGE (In years last birthday) 3		IF UNDER 1 YEAR Months 3 Days 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Willie L. RUSH		14. MOTHER'S MAIDEN NAME Juanita DEAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Willie L. Rush (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 hr. 48 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 April , 19 58 , to 17 April , 19 58 , that I last saw the deceased alive on 17 April 1958 , 19 58 , and that death occurred at 2:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth W. Sell		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
DATE SIGNED 4-18-58			
PHYSICIAN'S NAME (Type) KENNETH W. SELL, LT MC USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-58	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Bacon Funeral Home, 1722 7th St. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR APR 25 58	
24b. REGISTRAR'S SIGNATURE Qu. Beach			

205/203XV0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

APR 25 1958

RECEIVED

4839 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> <u>83x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>2006 Monroe St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Donald F SANDERS</u>				4. DATE OF DEATH Month Day Year <u>April 2 19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>March 8, 1888</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>23</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Statler Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Donald J. Sanders</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Allard M. Sanders-brother</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO <u>with myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19 54</u> to <u>April 2 19 58</u> , that I last saw the deceased alive on <u>4-1-19 58</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph A. Bailey</u>		ADDRESS (Street, city or town, state) <u>Wash. Clinic, Wash. D. C.</u>					
PHYSICIAN'S NAME (Type) <u>Joseph A. Bailey</u>		DATE SIGNED <u>Wash. Clinic, Wash. D. C.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burials</u>		22b. DATE THEREOF <u>4/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunnyside</u>		22d. LOCATION (City, town, or county) (State) <u>Orangeburg, S. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2839



WYIM BOARD

BUREAU V. 3

APR 7 1959

RECEIVED

4840 CERTIFICATE OF DEATH

04826

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Massachusetts</i> b. COUNTY <i>Middlesex</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda MD</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Holliston 15X1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		d. STREET ADDRESS <i>None</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Waldo Hammond Sargent</i>		4. DATE OF DEATH Month Day Year <i>April 29 - 1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-4-1891</i>
9. AGE (In years last birthday) <i>67 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building Contractor</i>	
11. BIRTHPLACE (State of foreign country) <i>Boston Mass</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Nelson Sargent</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Ricker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Alice Maxwell (daughter)</i>		Address <i>9408 Sunnyside Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardio-Vascular Renal disease</i> DUE TO (c) <i>Chronic</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none other</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6-17-58</i> , 19 <i>58</i> , to <i>4-29-58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4-29-58</i> , 19 <i>58</i> , and that death occurred at <i>7:30 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank C. Williamson</i> M.D. <i>2731 Conn. av. N.W. Wash. DC 4/24/58</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Frank C. Williamson M.D. 2731 Conn. av. N.W. Wash. DC</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-Transit</i>	22b. DATE THEREOF <i>4/30/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Lake Grove</i>	22d. LOCATION (City, town, or county) (State) <i>Holliston, Massachusetts</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4841 CERTIFICATE OF DEATH

Reg. Dist. No.

04827

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 hr. 38 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminister</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Carroll</u> Last <u>Schrider</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1958</u>
9. AGE (In years last birthday) yrs. <u>38</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u> Hours <u>38</u> Mins <u>38</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Benjamin Schrider</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Elaine Griffith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (2 1/2 lbs)</u> <u>761.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>761.0</u> DUE TO (c) <u>761.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Placenta abruptio of mother</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>11:50 PM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 27, 1958</u> , to <u>April 27, 1958</u> , that I last saw the deceased alive on <u>April 27, 1958</u> , and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Charles S. Whitaker, M.D.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M. D., Clarksville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4-28-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Morgan Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Waltz, Winfield, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 29 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Waltz</u>			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

BUREAU V. S.

APR 20 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4714

CERTIFICATE OF DEATH

Reg. Dist. No.

04829

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>50 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. EMILIE Anna Schuler</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1897</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>10</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Kirner</u>		14. MOTHER'S MAIDEN NAME <u>Suzanna Kaul</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-12-2066</u>	
17. INFORMATION <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of Liver</u> DUE TO (c) <u>8.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 years</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Suppurative Pyelonephritis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 21</u> , 19 <u>58</u> , to <u>April 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 2</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. B. Orleans</u>		ADDRESS (Street, city or town, state) <u>9500 Colossus Rd SS Md</u>	
PHYSICIAN'S NAME (Type) <u>H. B. ORLEANS, MD</u>		DATE SIGNED <u>APR 7 '58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm E. Humphrey</u>		ADDRESS <u>8434 9th Ave SS Md</u>	
24a. REC'D BY REGISTRAR <u>Wheeler</u>		24b. REGISTRAR'S SIGNATURE <u>Wheeler</u>	

RECEIVED

APR 7 1958

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #4 - Film G228 - 4/22/58-mb

04830

CERTIFICATE OF DEATH

Reg. Dist. No. 215

4342

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1320 "D" Street, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Franz		First Xavier		Last SCHUMM		4. DATE OF DEATH Month April Day 14 Year 1958	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 December 1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 14 Hours 12 Min.		IF UNDER 24 HRS. Months 7 Days 14 Hours 12 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps Band		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps (Retired)		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Stephen SCHUMM		14. MOTHER'S MAIDEN NAME Anna Maria NICKLAS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT (Wife) Mrs. Elizabeth A. SCHUMM (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 Days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 April , 19 58 , to 14 April , 19 58 , that I last saw the deceased alive on 14 April , 19 58 , and that death occurred at 9:13P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G.E. Gorsuch		M.D. U.S. Naval Hospital, Bethesda, Md.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.		DATE SIGNED 4-15-58	
PHYSICIAN'S NAME (Type) G.E. GORSUCH, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Mattingly		ADDRESS Mattingly Funeral Home, 131 11th St. S.E. Wash. D.C.		24a. REGISTRY RECORD APR 18 '58		24b. REGISTRY'S SIGNATURE W. F. Smith	

CERTIFICATE OF DEATH

DECEASED: JOHN J. BROWN
 SEX: MALE AGE: 65
 DATE OF BIRTH: 1893
 PLACE OF BIRTH: NEW YORK
 OCCUPATION: CLERK
 CAUSE OF DEATH: HEART DISEASE
 PLACE OF DEATH: HOME
 DATE OF DEATH: APR 18 1958
 SIGNATURE: [Signature]
 REGISTERED: [Signature]
 COUNTY: BALTIMORE
 CITY: BALTIMORE
 STATE: MARYLAND

BUREAU V. S.

APR 18 1958

RECEIVED

STAM BOND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4843

CERTIFICATE OF DEATH

Reg. Dist. No. 04828

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83X-3	
3. NAME OF DECEASED (Type or print) First Hurley Middle Everett Last Scott		4. DATE OF DEATH Month April Day 10 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 November 1957
9. AGE (In years last birthday) yrs. 4 Months 22 Days 8 Hours 10 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel E. Scott		14. MOTHER'S MAIDEN NAME Adeline Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Anoxia DUE TO (c) Congenital Heart Disease, Cyanotic		INTERVAL BETWEEN ONSET AND DEATH 7 Hours 7 Hours Life	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Catheterization		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 6 , 19 58 , to April 10 , 19 58 , that I last saw the deceased alive on April 10 , 19 58 , and that death occurred at 9:15P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John Waldhausen		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/11/58	
PHYSICIAN'S NAME (Type) JOHN WALDHAUSEN M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-14-58	
22c. NAME OF CEMETERY OR CREMATORY Cameron Memorial		22d. LOCATION (City, town, or county) (State) Beltville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James C. Churn		ADDRESS Arlington, Va.	
24a. REC'D BY REGISTRAR DATE APR 15 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

CERTIFICATE OF DEATH

1. NAME OF DECEASED The Baltimore Hospital, Baltimore, Md.		2. SEX Male		3. AGE 35	
4. OCCUPATION Physician		5. MARITAL STATUS Married		6. PLACE OF BIRTH Maryland	
7. DATE OF DEATH April 10, 1933		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH The Baltimore Hospital, Baltimore, Md.	
10. CAUSE OF DEATH Myocardial infarction, coronary artery disease, cerebral anoxia, respiratory insufficiency		11. MEDICAL HISTORY The deceased had been suffering from coronary artery disease for several years. He had also had a cerebral anoxia attack several months ago. He was admitted to the hospital on April 8, 1933, with a diagnosis of myocardial infarction. He died on April 10, 1933.			
12. SIGNATURE OF PHYSICIAN J. Edgar Hoover		13. SIGNATURE OF WITNESSES J. Edgar Hoover, M.D. J. Edgar Hoover, M.D.			

RECEIVED
BUREAU V. S.
APR 15 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18										04831	
Item 18 Film 230 6-6-58 ams										Reg. Dist. No. 215	
4844										CERTIFICATE OF DEATH	
1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park 18x-2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.					d. STREET ADDRESS Route 235 (Blue Room Bar)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stanislaus Middle Joseph Last SEDLAYWICZ					4. DATE OF DEATH Month April Day 14 Year 19 58						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 May 1916		9. AGE (In years last birthday) yrs. 41		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner					10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Joseph Sedlaywicz					14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW-II					16. SOCIAL SECURITY NO. 220 34-4578		17. INFORMANT Official Navy Records Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 Bleeding/Acute Hepatic failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fatty Liver DUE TO (c) Chronic Alcoholism										INTERVAL BETWEEN ONSET AND DEATH Sudden Unk Unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peritonitis due to Rupture of Bladder										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 10 April , 19 58 , to 14 April , 19 58 , that I last saw the deceased alive on 14 April , 19 58 , and that death occurred at 11:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 4-16-58											
ACTUAL SIGNATURE Melvin Rotner					M.D. U.S. Naval Hospital, Bethesda, Md.						
PHYSICIAN'S NAME (Type) Melvin Rotner, LT, MC, USN					U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 4-21-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Chambers, 1400 Chapin St. N.W. Washington, D.C.					ADDRESS		24a. REC'D BY REGISTRAR APR 18 '58		24b. REGISTRAR'S SIGNATURE Deedman		

CERTIFICATE OF DEATH

BUREAU V. S.

APR 18 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04832

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7111 Carroll Ave.		e. STREET ADDRESS 7111 Carroll Ave.	
3. NAME OF DECEASED (Type or print) First Katherine Middle Shadel Last		4. DATE OF DEATH Month April Day 20 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1880
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Wis.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Holmes		14. MOTHER'S MAIDEN NAME McCloskey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs Hazel Anderson (same as #2)	
17. INFORMANT Mrs Hazel Anderson (same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Hypertention Conditions, if any, which gave rise to immediate cause (b) (c) (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN DEATH AND DISCOVERY Found dead in bed years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE: Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Interment Burial April 22, 1958		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY St. John's Evangelical Cemetery		22d. LOCATION (City, town, or county) (State) Ansedale, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 257 Carroll St NW Wash. D.C.		24a. REC'D BY REGISTRAR DATE APR 22 '58	
		24b. REGISTRAR'S SIGNATURE Arthur Walters	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 22 1968

BUREAU V. 2

FOR STATE
HEALTH OFF

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4716 CERTIFICATE OF DEATH

04833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen. & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Victoria Beatrice SHARPE</u>				4. DATE OF DEATH <u>April 12 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-3-73</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Moseley</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock from Evisceration</u> DUE TO <u>794x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Low tensal strength of fascia</u> DUE TO <u>Malnutrition of Advanced Age</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I (a).							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>58</u> , to <u>April 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>58</u> , and that death occurred at <u>10:20</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>4/13/1958</u>							
ACTUAL SIGNATURE <u>Wilfred W. Eastman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Wilfred W. Eastman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/13/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Augusta, Georgia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paulers</u>				ADDRESS <u>1752 P. Ave. Wash. D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

CERTIFICATE OF DEATH

BUREAU V. B.

APR 15 1958

RECEIVED

04834

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 yrs 9 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harriet Vinton</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 5, 1872</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>? Jones</u>		14. MOTHER'S MAIDEN NAME <u>Kate Lecompte</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert C. Simmons</u>		Address <u>Bethesda Md 9311 E. Parkhill Dr</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Dis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April</u> , 19 <u>58</u> , and that death occurred at <u>6:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DeWitt E. DeLawter</u>		DATE SIGNED <u>4/18/58</u>	
PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLawter, Md.</u>		ADDRESS (Street, city or town, state) <u>8025 ABERDEEN RD. Bethesda Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

CERTIFICATE OF DEATH

Reg. Form 100

1. NAME OF DECEASED VICTIM		2. SEX Male		3. AGE 30		4. DATE OF BIRTH 1910		5. PLACE OF BIRTH Boston, Mass.	
6. OCCUPATION Police Officer		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH April 21, 1938		14. TIME OF DEATH 10:30 AM		15. SIGNATURE OF PHYSICIAN [Signature]	
16. SIGNATURE OF REGISTRAR [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF DECEASED [Signature]		19. SIGNATURE OF NEXT OF KIN [Signature]		20. SIGNATURE OF BURIAL OFFICIAL [Signature]	

BUREAU V. S.

APR 21 1938

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4717 CERTIFICATE OF DEATH

Reg. Dist. No. 04835

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
c. LENGTH OF STAY IN 1b <u>8 hrs. 25 min</u>		d. STREET ADDRESS <u>693 Oglethorpe St., N.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leah</u> Middle <u>None</u> Last <u>Simon</u>		4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-10</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harry Simon</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Feinberg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Washington Sanitarium + Hospital Records</u>	
17. INFORMANT <u>Washington Sanitarium + Hospital Records</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obesity</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 8</u> , 19 <u>58</u> , to <u>April 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 26</u> , 19 <u>58</u> , and that death occurred at <u>2:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Arthur S. Bresler</u> M.D.		PHYSICIAN'S NAME (Type) <u>ARTHUR S. BRESLER</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Leo Wash Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217-9th N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 29 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Bresler</u>			

APR 29 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4846 CERTIFICATE OF DEATH

Reg. Dist. No. 215

04836

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cynthia Middle Ann Last SLAYDEN		4. DATE OF DEATH Month April Day 2 Year 1958	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1933
9. AGE (In years last birthday) 25 yrs.		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Will WHITEHEAD		14. MOTHER'S MAIDEN NAME Jimmie Florence BEAUCHAMP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not known	
17. INFORMANT (Husb) Harold L. Slayden		Address Same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 29 , 19 58 , to April 2 , 19 58 , that I last saw the deceased alive on April 2 , 19 58 , and that death occurred at 7:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, Bethesda, Md DATE SIGNED 4/3/58			
ACTUAL SIGNATURE F. H. O'Connell		M.D. U. S. Naval Hospital, Bethesda, Md	
PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LT, MC, USN		U. S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY 755 Wisconsin Ave.		22d. LOCATION (City, town, or county) (State) England Arkansas	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. PUMPHREY FUNERAL HOME Bethesda, Md.		24a. REC'D BY REGISTRAR APR 7 '58	
24b. REGISTRAR'S SIGNATURE Al. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

APR 2 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

Date of Death		Place of Death	
March 30, 1958		The Clinical Center, The Johns Hopkins Hospital, Baltimore 18, Md.	
Age		Sex	
56 years		Male	
Race		Cause of Death	
White		Myocardial infarction, coronary artery disease, atherosclerosis, hypertension, chronic kidney disease, diabetes mellitus, hyperlipidemia, and smoking.	
Birth Date		Birth Place	
April 22, 1902		Baltimore, Maryland	
Married Name		Occupation	
John A. Smith		Retired	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
The Clinical Center, The Johns Hopkins Hospital, Baltimore 18, Md.		The Registrar, Baltimore, Md.	

04838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		1636.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 405 57th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Agnes		First Gordon		Middle Smith		Last April 28, 1958	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1887	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Package Wrapper				10b. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (State or foreign country) Minnesota	
13. FATHER'S NAME George Swanson				14. MOTHER'S MAIDEN NAME Elizabeth Gordon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Methotrexate Toxicity 190.9 DUE TO (b) (therapy for) Malignant Melanoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 7, 1958 , to April 28, 1958 , that I last saw the deceased alive on April 28, 1958 and that death occurred at 6:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/29/58 ACTUAL SIGNATURE Roger Lester M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Roger Lester, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS 2022 Washington St.		24a. REC'D BY REGISTRAR DATE MAY 2 '58	
				24b. REGISTRAR'S SIGNATURE Alfred			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

Reg. No. 11

Deceased Name

Birth Name

Age

Sex

12 years

102 5th Avenue

102 5th Avenue

102 5th Avenue

102 5th Avenue

102 5th Avenue

102 5th Avenue

102 5th Avenue

102 5th Avenue

102 5th Avenue

102 5th Avenue

102 5th Avenue

102 5th Avenue

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102 5th Avenue

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102 5th Avenue

102 5th Avenue

102 5th Avenue

102 5th Avenue

4849 CERTIFICATE OF DEATH

04839

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Mont. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Saniterium</u>		d. STREET ADDRESS <u>8600 Manchester Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Moulton</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-1869</u> 88 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Henry Moulton</u>		14. MOTHER'S MAIDEN NAME <u>Barch Carpenter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Margaret Smith</u> Address <u>8600 Manchester Rd.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema.</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease.</u> DUE TO (c) <u>Arteriosclerosis, generalized.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema, senile</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 hours.</u> <u>10 years.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1955</u> , to <u>April 1958</u> , that I last saw the deceased alive on <u>24 March 1958</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Seruch T. Kimble</u>		M.D. <u>929 P. Leaning Ave., Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>		DATE SIGNED <u>7 Apr 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>4/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MAYFLOWER HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>TAUNTON, MASS.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al L. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4850 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 108 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, NNM, Bethesda, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 3020 Porter St., N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last Chandler White SMITH		4. DATE OF DEATH Month Day Year April 9 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-83
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor		10b. KIND OF BUSINESS OR INDUSTRY Medicine	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles G. SMITH		14. MOTHER'S MAIDEN NAME Eliza Lloyd WHITE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI & WWII		16. SOCIAL SECURITY NO. 577 50 6952	
17. INFORMANT (Wife) Philena P. Smith, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis, multiple 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 weeks			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2 , 19 58 , to April 9 , 19 58 , that I last saw the deceased alive on April 9 , 19 58 , and that death occurred at 5:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM DATE SIGNED 4-10-58			
ACTUAL SIGNATURE T. S. DUNN, JR., LT, MC, USN M.D.		PHYSICIAN'S NAME (Type) Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-14-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons		24a. REC'D BY REGISTRAR APR 14 1958	
24b. REGISTRAR'S SIGNATURE Joseph Gawler's & Sons		24c. ADDRESS 1756 Penna. Ave. NW	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 14 1938

BUREAU V. 3

STATE CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4851

Reg. Dist. No.

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY

Montg.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Germantown

c. LENGTH OF STAY IN TB

13 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

The Marylander Nursing Home

f. STREET ADDRESS

9613 Page Ave.

e. IS RESIDENCE

ON A FARM?

YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)First
Clara WMiddle
Smith

Last

4. DATE
OF
DEATH

Month

Day

Year

April 6, 1958

19

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9/7/1874

9. AGE (In years
last birthday)83
yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School matron

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

W.VA.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George Smith

14. MOTHER'S MAIDEN NAME

Cordelia Engel

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Nursing Home Record

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a. m.
p. m.

19

20d. INJURY OCCURRED

While of work ☐ Not while of work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL
SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

April 6, 1958

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

4-9-58.

22c. NAME OF CEMETERY OR CREMATORY

Norland Cemetery

22d. LOCATION (City, town, or county)

Chambersburg, Pa.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Barbour Funeral Home Chambersburg Pa

ADDRESS

24a. REC'D BY REGISTRAR

DATE APR 9 '58

24b. REGISTRAR'S SIGNATURE

R. L. Leach

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] years
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

DISPOSITION OF BODY: [illegible]
SIGNATURE OF DISPOSER: [illegible]
DATE: [illegible]

BUREAU V. R.

APR 9 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04842

Reg. Dist. No.

4718

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b <u>10 min</u>				d. STREET ADDRESS <u>8106 Old Riggs Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Francis</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-31-08</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Marshall Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Agnes Archer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Evelyn Smith—same—Wife</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-30-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. D.C.</u>	
22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u>				ADDRESS <u>131-11 St. N.W.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		PLACE OF DEATH [Faint text]	
SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
PRESENT ILLNESS [Faint text]		POST-MORTEM EXAMINATION [Faint text]	
SIGNATURE OF EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]	
CERTIFICATE NO. [Faint text]		COUNTY [Faint text]	
CITY [Faint text]		STATE [Faint text]	

A 201 W 3000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #8- Film G228 - 4/21/58 - mb

CERTIFICATE OF DEATH

04843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
c. LENGTH OF STAY IN 1b <u>3 days</u>				d. STREET ADDRESS <u>525 Orchard Way</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dora Verina Smoot</u>			4. DATE OF DEATH <u>April 8 1958</u>				
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/2/79</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Lockstamper</u>				14. MOTHER'S MAIDEN NAME <u>Melissa Whittington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Charles H. Smoot, 525 Orchard Way Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pneumococcal meningitis</u> 340.1 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 5</u> , 19 <u>58</u> , to <u>April 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>58</u> , and that death occurred at <u>1:07 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr.</u>				ADDRESS (Street, city or town, state) <u>9301 Colesville Rd., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>BENNET A. PORTER, JR.</u>				DATE SIGNED <u>Apr. 9, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>April 11, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. E. Humphrey 8434 LaCure Sp. Md.</u>				24a. REC'D BY REGISTRAR <u>APR 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albert Leach</u>	

CERTIFICATE OF DEATH

MINOR BOOK

DEATH

BURIAL K.A.

APR 11 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04844

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

4852

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Canada</u> b. COUNTY <u>Ont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Chevy Chase</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barrie</u> <u>90 x -3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3407 Inverness Dr</u>				d. STREET ADDRESS <u>20 Blake St</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Sebastien</u> Last <u>Spiera</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/19/1984</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u> ✓	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Jean Yalloway (daughter)</u> Address <u>Same as item 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	Month, Day, Year <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Trans</u>		22b. DATE THEREOF <u>4/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Barrie Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Barrie, Ontario</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 14 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4853 CERTIFICATE OF DEATH

Reg. Dist. No. 04845

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 106 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1141 North Wood Road			
3. NAME OF DECEASED (Type or print) First Dorothy Middle Jeanne Last Stafford				4. DATE OF DEATH Month April Day 20 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 9, 1934	
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Dwayne Pottorf				14. MOTHER'S MAIDEN NAME Maxine Slutz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chorio Carcinoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 mos 8-10 mos							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 4, 19 58 , to April 20, 19 58 , that I last saw the deceased alive on April 20, 19 58 , and that death occurred at 4:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4-20-58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Charles F. Nadler M.D.							
PHYSICIAN'S NAME (Type) Charles F. Nadler, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/21/58		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Peoria, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE APR 23 '58		24b. REGISTRAR'S SIGNATURE Paul Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18-25

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIAGE		OCCUPATION	
EDUCATION		RELIGION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	

BUREAU T. B.

APR 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04846

4854

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home				d. STREET ADDRESS 1207 Geranium St. N.W.			
3. NAME OF DECEASED (Type or print) First JOHN Middle DENNIS Last STOCKTON				4. DATE OF DEATH Month April Day 15 Year 1958			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 7, 1871	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher		10b. KIND OF BUSINESS OR INDUSTRY Ranch		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Meredith Stockton				14. MOTHER'S MAIDEN NAME Not Available			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Lorena S. Shumaker, (same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular Fibrillation (c) Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH two hours 10 Days 10 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3, 1958 to April 15, 1958 , that I last saw the deceased alive on Apr 10, 1958 , and that death occurred at 10:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord St. DATE SIGNED Apr 15, 58 ACTUAL SIGNATURE Robert T. Thibadeau, M.D. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. Kensington, Md.							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		April 17, 1958		George Washington Cemetery		Prince Georges Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters, 254 Carroll St. N.W. Wash DC				24. DEC'D BY REGISTRAR APR 17 1958		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1880		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
Carpenter		High School		Married		JAN 15 1905		BALTIMORE		MD		USA			
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CITY		STATE		COUNTRY	
APR 17 1938		BALTIMORE		HEART DISEASE		NATURAL		YES		BALTIMORE		MD		USA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL		SIGNATURE OF CREMATION		SIGNATURE OF OTHER	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

APR 17 1938

RECEIVED

4720 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>4842 Bradley Blvd. Apt. 2</u>			
3. NAME OF DECEASED (Type or print) <u>Irving Edwin Strobel</u>				4. DATE OF DEATH Month <u>4</u> - Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-2-91</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Naval Architect Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>America</u>	
13. FATHER'S NAME <u>George E. Strobel</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Ford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobal pneumonia</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Possible myocardial infarction</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 19 <u>44</u> , to <u>4/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/13</u> , 19 <u>58</u> , and that death occurred at <u>11:00</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.F. McNeill</u>				M.D. <u>7602 Carroll Ave.</u>		DATE SIGNED <u>4/14/58</u>	
PHYSICIAN'S NAME (Type) <u>W.F. McNeill</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Outreach</u>	
				DATE <u>APR 15 58</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V. S.

APR 15 1938

RECEIVED

CORR. REGIONAL GEN.

WITNES

Boyle

Robert A. Murphy, Secretary

4855

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 46 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3601 Farragut St.		e. STREET ADDRESS 3601 Farragut St.	
3. NAME OF DECEASED (Type or print) First STELLA Middle W. Last STUBBS		4. DATE OF DEATH Month April Day 25 , Year 1958	
5. SEX Female	6. COLOR OR RACE Whiten	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1865
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Towanda, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Augustus Smith		14. MOTHER'S MAIDEN NAME Elizabeth Hardy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter		Address 3601 Farragut St. Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestive Heart FAILURE DUE TO (b) Arteriosclerosis Generalized DUE TO (c) Serious		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 June 14 , 19, to 4/25/58 , 19, that I last saw the deceased alive on 4/25/58 , 19, and that death occurred at 9:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel Allen		M.D. Kensington Maryland	
PHYSICIAN'S NAME (Type) SAMUEL ALLEN		DATE SIGNED 4-26-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-58	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE APR 28 '58		24b. REGISTRAR'S SIGNATURE Allen	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7228

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ACKNOWLEDGMENTS

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

2054, 2, 1, 1

135-0374

• 1970-1971

• **And, sweetest,**

BUREAU

1958 • 1958

RECEIVED

4856 CERTIFICATE OF DEATH

04849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 261 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 16 x - 2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route 1, Box 351			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Stephen Middle Lee Last Swiger				4. DATE OF DEATH Month April Day 5 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1940		9. AGE (In years last birthday) 17 yrs.	IF UNDER 1 YEAR Months 16 Days 8 Hours 2	IF UNDER 24 HRS Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Herbert R. Swiger				14. MOTHER'S MAIDEN NAME Georgianna Brissey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 355x Cardiac insufficiency and pulmonary edema DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypochloremic degeneration DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. 9 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from July 18 , 19 57 , to April 5 , 19 58 , that I last saw the deceased alive on April 5 , 19 58 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew G. Engel M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED _____			
PHYSICIAN'S NAME (Type) National Institutes of Health				ADDRESS Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial April 10, 1958		April 10, 1958		Headonridge Rem Park		Laurel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elizabeth Donaldson ADDRESS Laurel, Md.				24a. REC'D BY REGISTRAR APR 9 '58 DATE		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MADE IN U.S.A.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1-1-58

First Name

Last Name

Sex

Age

Color

Date of Birth

Place of Birth

Sex

Color

Date of Death

Place of Death

Sex

Color

Date of Death

Place of Death

Sex

Color

Date of Death

Place of Death

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Date of Death

Place of Death

Sex

Color

Date of Death

Place of Death

BUREAU K. 3

APR 9 1958

RECEIVED

4857

CERTIFICATE OF DEATH

Reg. Dist. No.

04850

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg,				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First SARAH Middle ELLEN Last THOMAS				4. DATE OF DEATH Month April Day 6 Year 1958			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1899	
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frederick Dorsey				14. MOTHER'S MAIDEN NAME Charlotte Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Seymour Thomas (Husband) Dickerson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) 5 years						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rt. Hemiparesis (Residual)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11 Oct , 19 53 to 6 April , 19 58 , that I last saw the deceased alive on 6 April , 19 58 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 7 Apr. 58 ACTUAL SIGNATURE Edwin W. Smith M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4/11/58		Arlington National		Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Shorrock				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR APR 15 '58	
				24b. REGISTRAR'S SIGNATURE Deborah			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES M. SMITH		2. SEX Male		3. AGE 45	
4. DATE OF DEATH April 10, 1958		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. MEDICAL HISTORY None	
10. SIGNATURE OF PHYSICIAN J. M. Smith		11. SIGNATURE OF WITNESS J. M. Smith		12. SIGNATURE OF DECEASED J. M. Smith	
13. SIGNATURE OF REGISTRAR J. M. Smith		14. SIGNATURE OF CLERK J. M. Smith		15. SIGNATURE OF CHIEF OF BUREAU J. M. Smith	

BUREAU V. S.

APR 15 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4858 CERTIFICATE OF DEATH

Reg. Dist. No.

04851

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Garrett Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5003 Cushing Drive				d. STREET ADDRESS 5003 Cushing Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia Middle K Last THOMPSON				4. DATE OF DEATH Month April Day 20 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1897	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 1 Days 6		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Edward Kingberger				14. MOTHER'S MAIDEN NAME Mary E. Lynch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Edwin C. Thompson-same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH. 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) (ADENOCARCINOMA) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 16 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6, 1957 , to April 20, 1958 , that I last saw the deceased alive on April 19, 1958 , and that death occurred at 4:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John F. Finnegan M.D.				ADDRESS (Street, city or town, state) 1746 "K" Street, N. W. Washington, D. C.			
PHYSICIAN'S NAME (Type) John F. Finnegan				1746 "K" Street, N. W. Washington, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/58		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR APR 23 1958	
				24b. REGISTRAR'S SIGNATURE W. E. E. E. E.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. E.

APR 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04852

4721

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u> <u>06 X-2</u> d. STREET ADDRESS <u>Paradise Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																															
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Roscoe</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>7</u> - Year <u>1958</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-21-1893</u>		9. AGE (In years last birthday) <u>65</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.														
IF UNDER 1 YEAR		IF UNDER 24 HRS.																																	
Months	Days	Hours	Min.																																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Public Utilities</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>																									
13. FATHER'S NAME <u>John M. Thompson</u>						14. MOTHER'S MAIDEN NAME <u>Amelia Condon</u>																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>217-10-9747</u>				17. INFORMANT <u>Mrs. Pearl Thompson</u> Address <u></u>																											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="10" style="vertical-align: top;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u> </td> <td colspan="2" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> </td> </tr> <tr> <td colspan="10" style="vertical-align: top;"> DUE TO (b) DUE TO (c) </td> <td colspan="2"></td> </tr> </table>												PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u>										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>		DUE TO (b) DUE TO (c)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u>										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>																									
DUE TO (b) DUE TO (c)																																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																															
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u></u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)																							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																																			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>																													
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																													
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>4-7-58</u>																													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>4-10-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PINE GROVE</u>				22d. LOCATION (City, town, or county) <u>Mt. Airy</u> (State) <u>MD.</u>																									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Hartz</u>						ADDRESS <u>Winfield Md.</u>																													
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Wm. Hartz</u>				DATE <u>APR 10 '58</u>																											

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04853

Reg. Dist. No.

4725

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>	
		d. STREET ADDRESS <u>13108 GRENOBLE DRIVE</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>M.</u> Last <u>TONNEMAN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 17, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH ANDRESKY</u>		14. MOTHER'S MAIDEN NAME <u>MARIE SUVA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-36-5381</u>	
17. INFORMANT <u>HARRY I. TONNEMAN</u>		Address <u>Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Pulmonary edema</u> DUE TO (b) <u>Congestive Heart failure</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>8 weeks</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August, 1953</u> , to <u>April 21, 1958</u> , that I last saw the deceased alive on <u>April 21, 1958</u> , and that death occurred at <u>7:50 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Patten</u> M.D.		ADDRESS (Street, city or town, state) <u>8641 Colasville Road Silver Spring Md</u>	
DATE SIGNED <u>4/21/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		ADDRESS <u>3821 14th. St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>APR 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>R. L. Leach</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4859

Reg. Dist. No.

04854

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garthursburg</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Garthursburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>51 W. Diamond Ave</u>				d. STREET ADDRESS <u>151 W. Diamond Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alvin</u> Middle <u>Trevey</u> Last <u>Trevey</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 5, 1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Jacob C. Trevey</u>				14. MOTHER'S MAIDEN NAME <u>Florence Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wm. Thompson Watts, Proctor and</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of throat with metastasis</u> DUE TO (c) <u>2 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>148X</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town or county) (State) <u>Garthursburg md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emil B. Garton</u> ADDRESS <u>Garthursburg md.</u>				24a. REC'D BY REGISTRAR <u>APR 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

BUREAU V. 3

APR 29 1958

RECEIVED

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social Status	
Medical History		Previous Illnesses		Present Illness		Treatment		Prognosis		Remarks	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Juror		Signature of Witness		Signature of Deceased	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4860

CERTIFICATE OF DEATH

04855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>E.</u> Last <u>UPPERMAN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/06</u>
9. AGE (In years last birthday) <u>51 1/2</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Budget Officer U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Walter Upperman</u>		14. MOTHER'S MAIDEN NAME <u>Fox, Mary D.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Anna E Upperman</u>		Address <u>Bethesda 5033 Alta Vista Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary occlusion</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1949</u> , 19 <u></u> , to <u>Apr. 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Apr. 6</u> , 19 <u>58</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4535 Yuma St NW</u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>Malcolm D Harrison</u> M.D.		PHYSICIAN'S NAME (Type) <u>Malcolm D. Harrison</u> Wash 16 PC	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 8 '58</u>	24b. REGISTRAR'S SIGNATURE <u></u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 8 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04856

4861 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5013 Strathmore Ave.</u>				d. STREET ADDRESS <u>5013 Strathmore Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>E.</u> Last <u>WARFIELD</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> , Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14, 1884</u>	
9. AGE (In years last birthday) yrs. <u>73</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Acct. B & O R.R. -</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S</u>		13. FATHER'S NAME <u>J. Latimer Warfield</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Lewis</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Sister</u> <u>Edith W. Tabler</u> Address <u>Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 14, 1955</u> to <u>April 18 1958</u> , that I last saw the deceased alive on <u>April 17, 1958</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert H. Coale</u>		M.D. <u>4630 Montgomery Ave.</u>		DATE SIGNED <u>4/18/58</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		<u>Bethesda, Md.</u>		22. LOCATION (City, town, or county) (State) <u>Hyattstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hyattstown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>APR 21 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>				24c. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

BUREAU V. S.

APR 21 1958

RECEIVED

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		RACE		RELIGION	
MARRIED		SINGLE		WIDOW	
EDUCATION		OCCUPATION		CAUSE OF DEATH	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
OCCUPATION		OCCUPATION		OCCUPATION	
EDUCATION		EDUCATION		EDUCATION	
MARRIED		MARRIED		MARRIED	
SINGLE		SINGLE		SINGLE	
WIDOW		WIDOW		WIDOW	
RELIGION		RELIGION		RELIGION	
RACE		RACE		RACE	
SEX		SEX		SEX	
NAME OF DECEASED		NAME OF DECEASED		NAME OF DECEASED	

BUREAU V. S.

APR 7 1958

RECEIVED

4863 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NNMC, Bethesda, Md.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> <u>83X-3</u>	
f. STREET ADDRESS <u>2000 4th Street South</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Anne</u> Last <u>WEINBECK</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-58</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leo William WEINBECK</u>		14. MOTHER'S MAIDEN NAME <u>Arliss Maxine DOROFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(Father) Leo W. Weinbeck, same as #2 above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apnea</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>2 day</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 7</u> , 19 <u>58</u> , to <u>April 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>58</u> , and that death occurred at <u>12:30A</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kenneth W. Sell</u> M.D.		ADDRESS (Street, city or town, state) <u>U. S. Naval Hospital, NNMC</u> DATE SIGNED <u>4-9-58</u>	
PHYSICIAN'S NAME (Type) <u>K. W. SELL, LT, MC, USN</u>		<u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. K. Humphrey</u> <u>Funeral Home, 7557 Wisconsin Ave</u>		24a. REC'D BY REGISTRAR <u>APR 11 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Red Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF BIRTH



Blank form area for birth certificate details, including fields for name, date, and location.

BUREAU V. S.

APR 11 1958

RECEIVED

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Albany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>56 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>		d. STREET ADDRESS <u>511 Bradford St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Weir</u> Last <u>Weir</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-85</u>
9. AGE (In years last birthday) yrs. <u>72</u>		10. IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chauncey Weir</u>		14. MOTHER'S MAIDEN NAME <u>Martha Meyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism - lftes</u> DUE TO <u>Mediastinal & pleural inflammation</u> DUE TO <u>Spontaneous ruptured aortic aneurysm</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u> <u>2 wks.</u> <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystitis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-20</u> , 19 <u>58</u> , to <u>4-15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-15</u> , 19 <u>58</u> , and that death occurred at <u>2:30</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Brownshug</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Cornell Ave. - Takoma Park - Md</u>	
DATE SIGNED <u>April 19, 1958</u>		PHYSICIAN'S NAME (Type) <u>John F. Brownshug</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit Burial</u>		22b. DATE THEREOF <u>April 19, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Arthur Walters</u>		ADDRESS <u>254 Carroll St. - N.W.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Paul</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 17 1958

RECEIVED

4864

CERTIFICATE OF DEATH

Reg. Dist. No.

04860

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 478-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1801 Park Road N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph Franklin Whalen</u>				4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 25, 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry E. Whalen</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Mrs. Edna W. Warthen - Daughter Cherry Chase</u>				Address <u>4000 Homewood St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> <u>442X</u> DUE TO <u>Generalized atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 yrs</u> (c) <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> <u>Fracture right hip</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/28</u> , 19 <u>58</u> , to <u>4-17-58</u> , that I last saw the deceased alive on <u>4-16-1958</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
21. I certify that I attended the deceased from <u>3/28</u> , 19 <u>58</u> , to <u>4-17-58</u> , that I last saw the deceased alive on <u>4-16-1958</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>370 Connel Ave. W. Wash. D.C.</u> DATE SIGNED <u>4-17-58</u>			
ACTUAL SIGNATURE <u>C. Roger Kurtz, M.D.</u>							
PHYSICIAN'S NAME (Type) <u>C. Roger Kurtz, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>APR 21 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. WILSON		2. SEX MALE	
3. DATE OF DEATH APRIL 21 1958		4. TIME OF DEATH 10:00 AM	
5. PLACE OF DEATH HOME		6. AGE 68	
7. OCCUPATION RETIRED		8. MARITAL STATUS MARRIED	
9. CAUSE OF DEATH HEART DISEASE		10. MANNER OF DEATH NATURAL	
11. SIGNATURE OF PHYSICIAN DR. J. H. WILSON		12. SIGNATURE OF DECEASED JOHN J. WILSON	
13. SIGNATURE OF WITNESS JOHN J. WILSON		14. SIGNATURE OF WITNESS JOHN J. WILSON	
15. SIGNATURE OF WITNESS JOHN J. WILSON		16. SIGNATURE OF WITNESS JOHN J. WILSON	
17. SIGNATURE OF WITNESS JOHN J. WILSON		18. SIGNATURE OF WITNESS JOHN J. WILSON	
19. SIGNATURE OF WITNESS JOHN J. WILSON		20. SIGNATURE OF WITNESS JOHN J. WILSON	
21. SIGNATURE OF WITNESS JOHN J. WILSON		22. SIGNATURE OF WITNESS JOHN J. WILSON	
23. SIGNATURE OF WITNESS JOHN J. WILSON		24. SIGNATURE OF WITNESS JOHN J. WILSON	
25. SIGNATURE OF WITNESS JOHN J. WILSON		26. SIGNATURE OF WITNESS JOHN J. WILSON	
27. SIGNATURE OF WITNESS JOHN J. WILSON		28. SIGNATURE OF WITNESS JOHN J. WILSON	
29. SIGNATURE OF WITNESS JOHN J. WILSON		30. SIGNATURE OF WITNESS JOHN J. WILSON	
31. SIGNATURE OF WITNESS JOHN J. WILSON		32. SIGNATURE OF WITNESS JOHN J. WILSON	
33. SIGNATURE OF WITNESS JOHN J. WILSON		34. SIGNATURE OF WITNESS JOHN J. WILSON	
35. SIGNATURE OF WITNESS JOHN J. WILSON		36. SIGNATURE OF WITNESS JOHN J. WILSON	
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59. SIGNATURE OF WITNESS JOHN J. WILSON		60. SIGNATURE OF WITNESS JOHN J. WILSON	
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91. SIGNATURE OF WITNESS JOHN J. WILSON		92. SIGNATURE OF WITNESS JOHN J. WILSON	
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95. SIGNATURE OF WITNESS JOHN J. WILSON		96. SIGNATURE OF WITNESS JOHN J. WILSON	
97. SIGNATURE OF WITNESS JOHN J. WILSON		98. SIGNATURE OF WITNESS JOHN J. WILSON	
99. SIGNATURE OF WITNESS JOHN J. WILSON		100. SIGNATURE OF WITNESS JOHN J. WILSON	

RECEIVED
APR 21 1958
BUREAU V. S.

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM, WITHOUT PERMISSION IN WRITING FROM THE MARYLAND STATE DEPARTMENT OF HEALTH.

04861

Reg. Dist. No.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 36 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		05X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS RFD #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Cecil		Middle Howe		Last Wheatley, Jr.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month April			
				B. DATE OF BIRTH November 8, 1925		9. AGE (In years last birthday) 32 yrs.			
						IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Cecil Wheatley, Sr.				14. MOTHER'S MAIDEN NAME Mary Carroll					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 2-13-22-7555		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myelocytic Leukemia DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 24 , 19 58 , to April 29 , 19 58 , that I last saw the deceased alive on April 29 , 19 58 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4/30/58									
ACTUAL SIGNATURE Roger Lester		M.D. The Clinical Center		The National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) Roger Lester, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1958		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE MAY 6 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04862

Reg. Dist. No.

4866

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				d. STREET ADDRESS <u>5915 Conway Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Esther Aileen Wheeler</u>				4. DATE OF DEATH Month Day Year <u>Apr. 3, 1958 19</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>12/26/1910</u>		9. AGE (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing agent N.N.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Med. Center</u>		11. BIRTHPLACE (State or foreign country) <u>Wis.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John B. Litney</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Pope</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hosp. Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral destruction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>subduran and dissecting hematoma</u> DUE TO (c) <u>ruptured aneurysm, left mid-cerebral artery</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 hour</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>APR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1958



NAME OF DECEASED		DATE OF DEATH	
RESIDENCE		PLACE OF DEATH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
POST-MORTEM EXAMINATION		LABORATORY TESTS	
SIGNATURE OF EXAMINER		DATE OF SIGNATURE	
OFFICIAL SEAL		NOTARY SEAL	

BUREAU V. S.

APR 7 1958

RECEIVED

4867 CERTIFICATE OF DEATH

Reg. Dist. No. 04863

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5811 Maiden Lane		d. STREET ADDRESS 5811 Maiden Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETHEL Middle GRAY Last WILLIAMS		4. DATE OF DEATH Month April Day 28 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Frank Gray		14. MOTHER'S MAIDEN NAME Mary Anne Brawner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Walter M. Williams-same as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) generalized Carcinomatosis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of Breast DUE TO (c) 22 years 6 months		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV. 4/28 1958 to APRIL 28 1958 , that I last saw the deceased alive on 4/28 1958 , and that death occurred at 10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James J. Burns		ADDRESS (Street, city or town, state) 915-19th St. NW, Wash D.C.	
DATE SIGNED APR 28 1958			
PHYSICIAN'S NAME (Type) JAMES T. BURNS M.D. Wash D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE MAY 1 '58		24b. REGISTRAR'S SIGNATURE Alb...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED Robert A. Thompson		DATE OF DEATH June 21, 1953	
PLACE OF DEATH Home		AGE 68	
SEX Male		RACE White	
MARRIAGE Married		EDUCATION High School	
OCCUPATION Retired		RELIGION Methodist	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF DEATH REGISTRAR J. H. Smith	
DATE OF SIGNATURE June 22, 1953		PLACE OF SIGNATURE Baltimore, Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4868 CERTIFICATE OF DEATH

04864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Montgomery County General Hospital, Inc.</u>		d. STREET ADDRESS <u>Derwood</u>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>Norris</u> Last <u>Windsor</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1.18.02</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Doras Windsor</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Brady</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>151X</u> DUE TO (c) <u>lung abscess, left lower lobe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>lung abscess, left lower lobe</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/25, 1958</u> to <u>4/25, 1958</u> that I last saw the deceased alive on <u>4/25, 1958</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur F. Woodward</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>4/25/58</u>	
PHYSICIAN'S NAME (Type) <u>A. F. Woodward, M. D., Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-1-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sullivan Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Derwood</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Garton</u>		ADDRESS <u>Garton & Son</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Seuch</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		Male		35		White		April 22, 1928		Memphis, Tennessee		April 4, 1968		Memphis, Tennessee		Shot		Suicide		J. Edgar Hoover		John Edgar Hoover	
13. FULL NAME OF PHYSICIAN		14. FULL NAME OF REGISTRAR		15. FULL NAME OF WITNESS		16. FULL NAME OF WITNESS		17. FULL NAME OF WITNESS		18. FULL NAME OF WITNESS		19. FULL NAME OF WITNESS		20. FULL NAME OF WITNESS		21. FULL NAME OF WITNESS		22. FULL NAME OF WITNESS		23. FULL NAME OF WITNESS		24. FULL NAME OF WITNESS	
Dr. J. Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND.

4869

CERTIFICATE OF DEATH

Reg. Dist. No.

04865

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>10201 Meredith Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sybillo Alberta Wolfe</u>		4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 16, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>29</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elisha E. Mullinix</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rose Darling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Mary Wolfe Miller 10306 Brunswick Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>Right Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auricular fibrillation</u> DUE TO (c) <u>5 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1, 1953</u> , to <u>April 29, 1958</u> , that I last saw the deceased alive on <u>April 29, 1958</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Roger Hurtz</u>		ADDRESS (Street, city or town, state) <u>361 Conno. Rd. Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>C. Roger Hurtz, M.D.</u>		DATE SIGNED <u>4-29-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Mont. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 5 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. C. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4-25-64

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. PLACE OF BIRTH [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. OCCUPATION [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]	
10. MEDICAL HISTORY [Faint text]		11. PRESENT ILLNESS [Faint text]		12. DATE OF DEATH [Faint text]	
13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF CORONER [Faint text]		15. SIGNATURE OF WITNESS [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF NEXT OF KIN [Faint text]		18. SIGNATURE OF CLERK [Faint text]	
19. SIGNATURE OF CHURCH CLERK [Faint text]		20. SIGNATURE OF MINISTER [Faint text]		21. SIGNATURE OF RABBI [Faint text]	
22. SIGNATURE OF JEWELER [Faint text]		23. SIGNATURE OF BURIAL SOCIETY [Faint text]		24. SIGNATURE OF FUNERAL HOME [Faint text]	
25. SIGNATURE OF CEMETERY [Faint text]		26. SIGNATURE OF INTERMENT [Faint text]		27. SIGNATURE OF RECORDS [Faint text]	
28. SIGNATURE OF ARCHIVES [Faint text]		29. SIGNATURE OF INDEXING [Faint text]		30. SIGNATURE OF MICROFILMING [Faint text]	
31. SIGNATURE OF PHOTOGRAPHING [Faint text]		32. SIGNATURE OF TRANSCRIPTION [Faint text]		33. SIGNATURE OF REPRODUCTION [Faint text]	
34. SIGNATURE OF DISTRIBUTION [Faint text]		35. SIGNATURE OF STORAGE [Faint text]		36. SIGNATURE OF RETENTION [Faint text]	
37. SIGNATURE OF DESTRUCTION [Faint text]		38. SIGNATURE OF RECOVERY [Faint text]		39. SIGNATURE OF REPAIR [Faint text]	
40. SIGNATURE OF REPLACEMENT [Faint text]		41. SIGNATURE OF REINFORCEMENT [Faint text]		42. SIGNATURE OF RECONSTRUCTION [Faint text]	
43. SIGNATURE OF REFORMATION [Faint text]		44. SIGNATURE OF REFORMATION [Faint text]		45. SIGNATURE OF REFORMATION [Faint text]	
46. SIGNATURE OF REFORMATION [Faint text]		47. SIGNATURE OF REFORMATION [Faint text]		48. SIGNATURE OF REFORMATION [Faint text]	
49. SIGNATURE OF REFORMATION [Faint text]		50. SIGNATURE OF REFORMATION [Faint text]		51. SIGNATURE OF REFORMATION [Faint text]	
52. SIGNATURE OF REFORMATION [Faint text]		53. SIGNATURE OF REFORMATION [Faint text]		54. SIGNATURE OF REFORMATION [Faint text]	
55. SIGNATURE OF REFORMATION [Faint text]		56. SIGNATURE OF REFORMATION [Faint text]		57. SIGNATURE OF REFORMATION [Faint text]	
58. SIGNATURE OF REFORMATION [Faint text]		59. SIGNATURE OF REFORMATION [Faint text]		60. SIGNATURE OF REFORMATION [Faint text]	
61. SIGNATURE OF REFORMATION [Faint text]		62. SIGNATURE OF REFORMATION [Faint text]		63. SIGNATURE OF REFORMATION [Faint text]	
64. SIGNATURE OF REFORMATION [Faint text]		65. SIGNATURE OF REFORMATION [Faint text]		66. SIGNATURE OF REFORMATION [Faint text]	
67. SIGNATURE OF REFORMATION [Faint text]		68. SIGNATURE OF REFORMATION [Faint text]		69. SIGNATURE OF REFORMATION [Faint text]	
70. SIGNATURE OF REFORMATION [Faint text]		71. SIGNATURE OF REFORMATION [Faint text]		72. SIGNATURE OF REFORMATION [Faint text]	
73. SIGNATURE OF REFORMATION [Faint text]		74. SIGNATURE OF REFORMATION [Faint text]		75. SIGNATURE OF REFORMATION [Faint text]	
76. SIGNATURE OF REFORMATION [Faint text]		77. SIGNATURE OF REFORMATION [Faint text]		78. SIGNATURE OF REFORMATION [Faint text]	
79. SIGNATURE OF REFORMATION [Faint text]		80. SIGNATURE OF REFORMATION [Faint text]		81. SIGNATURE OF REFORMATION [Faint text]	
82. SIGNATURE OF REFORMATION [Faint text]		83. SIGNATURE OF REFORMATION [Faint text]		84. SIGNATURE OF REFORMATION [Faint text]	
85. SIGNATURE OF REFORMATION [Faint text]		86. SIGNATURE OF REFORMATION [Faint text]		87. SIGNATURE OF REFORMATION [Faint text]	
88. SIGNATURE OF REFORMATION [Faint text]		89. SIGNATURE OF REFORMATION [Faint text]		90. SIGNATURE OF REFORMATION [Faint text]	
91. SIGNATURE OF REFORMATION [Faint text]		92. SIGNATURE OF REFORMATION [Faint text]		93. SIGNATURE OF REFORMATION [Faint text]	
94. SIGNATURE OF REFORMATION [Faint text]		95. SIGNATURE OF REFORMATION [Faint text]		96. SIGNATURE OF REFORMATION [Faint text]	
97. SIGNATURE OF REFORMATION [Faint text]		98. SIGNATURE OF REFORMATION [Faint text]		99. SIGNATURE OF REFORMATION [Faint text]	
100. SIGNATURE OF REFORMATION [Faint text]		101. SIGNATURE OF REFORMATION [Faint text]		102. SIGNATURE OF REFORMATION [Faint text]	

CHIEF CLERK

DATE: 4-25-64
TIME: 10:00 AM
BY: [Signature]

4870 CERTIFICATE OF DEATH

Reg. Dist. No. **XX 215**

1. PLACE OF DEATH o. COUNTY Maryland <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia <i>COLUMBIA</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 8 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.			d. STREET ADDRESS 718 "C" Street, S.E.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Emile Middle "K" Last WUNDERLICH			4. DATE OF DEATH Month April Day 22 Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Sept. 1869	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Housewife)			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Gotlieb SEMMLER			14. MOTHER'S MAIDEN NAME Marie WARTH		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT (Friend) Mrs. Helene A. Au, 1019 Independence Ave.			Address S.E. Wash.D.C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial infarction (c) arteriosclerotic heart disease					INTERVAL BETWEEN ONSET AND DEATH 6 hours 12 hours 12 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture left femur - 7 days postoperative					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) Fell down while lifting flower pots			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 904.0 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. City or town Washington		(County)		(State)	
21. I certify that I attended the deceased from 14 April , 19 58 , to 22 April , 19 58 , that I lost saw the deceased alive on 22 April , 19 58 , and that death occurred at 11:00P M, from the causes and on the date stated above.					
ACTUAL SIGNATURE N. Thomas Debevoise		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
DATE SIGNED 4-23-58					
PHYSICIAN'S NAME (Type) N. Thomas Debevoise, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 25 Apr. 1958		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery	
22d. LOCATION (City, town, or county) Washington, D. C.		(State)			
24a. REC'D BY REGISTRAR Lee, 4th & Mass Ave., N.W. Washington, D.C.		DATE APR 30 58		24b. REGISTRAR'S SIGNATURE W. A. Lee	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES (JIM) J. JONES		MALE		35		JAN 1, 1930	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
BALTIMORE, MARYLAND		BALTIMORE		MARYLAND		UNITED STATES	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
LABORER		HIGH SCHOOL		METHODIST		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
HEART DISEASE		SUICIDE		2 WEEKS		HOME	
DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE	
JAN 15, 1965		10:00 AM		10		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

BUREAU V. S.

RECEIVED

FEB 20 1965

4871

CERTIFICATE OF DEATH

04867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 532 Fourth Avenue	
3. NAME OF DECEASED (Type or print) First Diane Middle (none) Last Yankow		4. DATE OF DEATH Month April Day 23 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 18, 1954
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter N. Yankow		14. MOTHER'S MAIDEN NAME Joan Schmelz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis and Hemorrhage 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Surgery DUE TO (c) Ventricular Septal Defect			INTERVAL BETWEEN ONSET AND DEATH 24 hours 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 6, 1958 , to April 23, 1958 , that I last saw the deceased alive on April 23, 1958 , and that death occurred at 12:22P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/23/58 ACTUAL SIGNATURE Louis Gillespie, Jr. M.D. PHYSICIAN'S NAME (Type) Louis Gillespie, Jr., M.D. National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-26-58	22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	22d. LOCATION (City, town, or county) (State) West field, New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Pumphrey		24a. REC'D BY REGISTRAR Md. APR 25 1958	24b. REGISTRAR'S SIGNATURE W. J. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES W. JONES		35		M		W		JAN 15 1925		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JULY 10 1945		BALTIMORE, MD.		JANE W. JONES		APR 10 1955		BALTIMORE, MD.	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
CLERK		JAN 15 1950		BALTIMORE, MD.		ABC COMPANY		APR 10 1955		BALTIMORE, MD.	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		APR 10 1955		BALTIMORE, MD.		DR. J. W. JONES		APR 10 1955		BALTIMORE, MD.	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		APR 10 1955		BALTIMORE, MD.		DR. J. W. JONES		APR 10 1955		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
J. W. JONES		APR 10 1955		BALTIMORE, MD.		DR. J. W. JONES		APR 10 1955		BALTIMORE, MD.	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH	
J. W. JONES		APR 10 1955		BALTIMORE, MD.		DR. J. W. JONES		APR 10 1955		BALTIMORE, MD.	

BUREAU V. S.

APR 25 1955

RECEIVED

Robert A. Humphrey 7527 Asc. Ave. Baltimore, Md. 4-30-55
 Arlington Cemetery
 West Hill, New Jersey

4872 CERTIFICATE OF DEATH

04868

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 4 1/2 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
f. STREET ADDRESS 241 S. Prospect St.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERTHA Middle ANN Last ZEIGLER				4. DATE OF DEATH Month April Day 20 Year 1958			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 19, 1861	
9. AGE (In years last birthday) 97 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sharpsburg, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Capt. R. C. Bamford				14. MOTHER'S MAIDEN NAME Margaret Atkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Asbury Methodist Home, Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO (c) hypertensive cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 16 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 499x							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown				20g. (County) Maryland		20h. (State) Maryland	
21. I certify that I attended the deceased from 5-2 , 19 56 , to 4-20 , 19 58 , that I last saw the deceased alive on 4-16 , 19 58 , and that death occurred at 11:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4208 Anthony St Kensington Md DATE SIGNED 4-20-58							
ACTUAL SIGNATURE Sarah E. Glover				M.D. 4208 Anthony St Kensington Md			
PHYSICIAN'S NAME (Type) Sarah E. Glover							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR APR 23 '58	
24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 23 1958